IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ASSOCIATION FOR COMMUNITY AFFILIATED PLANS, *et al.*, Plaintiffs, v. UNITED STATES DEPARTMENT OF TREASURY, *et al.*, Defendants.	Civil Action No. 18-2133 (RJL)

DEFENDANTS' MEMORANDUM OF LAW
IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT

TABLE OF CONTENTS

INTRODUCTION 1

STATUTORY AND REGULATORY BACKGROUND 4

I. HIPAA's Exclusion of "Short-Term Limited Duration Insurance" 4

II. The ACA's Retention of HIPAA's STLDI Exemption 4

III. The 2016 STLDI Rule 7

IV. The 2018 STLDI Rule 8

STANDARD OF REVIEW ON SUMMARY JUDGMENT 10

ARGUMENT 11

I. Plaintiffs' Claims Fail for Lack of Subject Matter Jurisdiction. 11

A. Plaintiffs Fail to Establish Standing on Behalf of Their Insurer-Members. 12

1. Plaintiffs Have Not Shown that Any Insurer Member Will Lose Enrollees to STLDI Plans. 12

2. Plaintiffs Have Not Shown that the Alleged Injury Is Traceable to the STLDI Rule or Redressable Through Its Invalidation. 17

3. The Competitor Standing Doctrine Does Not Apply. 21

B. Plaintiffs Fail to Establish Standing on Behalf of their Provider Members. 22

C. Plaintiffs Fail to Establish Standing on Behalf of their Consumer Members 24

II. Plaintiffs' Claims Fail on their Merits. 26

A. Standard of Review Under the APA 26

B. The STLDI Rule Is Comfortably Within the Departments' Authority. 27

C. The STLDI Rule Is Not Contrary to Law. 30

1. The STLDI Rule Is Consistent with the Statutory Text. 30

2. Congress Did Not Clearly Preclude the STLDI Rule. 32

D. The STLDI Rule Is Not Arbitrary and Capricious. 37

1. The Departments Considered Relevant and Appropriate Factors. 38

2. The Departments Provided a Well-Reasoned Explanation for Their Modification of the 2016 STLDI Rule..... 40

3. The Purported Harms that Plaintiffs Claim Will Result from the STLDI Rule Do Not Render It Unlawful..... 42

E. The Departments Satisfied the APA's Notice and Comment Requirements. 43

CONCLUSION..... 45

TABLE OF AUTHORITIES

CASES

Adirondack Med. Ctr. v. Sebelius,
891 F. Supp. 2d 36 (D.D.C. 2012), *aff'd*, 740 F.3d 692 (D.C. Cir. 2014) 37

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709 F.3d 29 (D.C. Cir. 2013) 27

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821 F.3d 44 (D.C. Cir. 2016), *cert denied*, 137 S. Ct. 1069 (2017) ..... *passim*

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No. 2:15-CV-3266-PMD, 2016 WL 4430839 (D.S.C. Aug. 22, 2016) 30

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135 F.3d 791 (D.C. Cir. 1998) 45

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563 U.S. 125 (2011) 11

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797 F.3d 11 (D.C. Cir. 2015) 21

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949 F. Supp. 2d 91 (D.D.C. 2013) 24

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419 U.S. 281 (1974) 38

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371 U.S. 156 (1962) 38

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814 F. Supp. 2d 230 (E.D.N.Y. 2011) 26

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467 U.S. 837 (1984) 26, 27

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401 U.S. 402 (1971) 11

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569 U.S. 290 (2013) 27

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568 U.S. 398 (2013) 11, 23

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113 F. Supp. 3d 197 (D.D.C. 2015) 27

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673 F.2d 525 (D.C. Cir. 1982) 44

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556 U.S. 303 (2009) 30

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48 F. Supp. 3d 1 (D.D.C. 2014) 25

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816 F. Supp. 2d 49 (D.D.C. 2011) 10

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67 F. Supp. 3d 81 (D.D.C. 2014) 11

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987 F.2d 913 (2d Cir. 1993) 25

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778 F.3d 158 (D.C. Cir. 2015) 28

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458 U.S. 564 (1982) 37

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693 F.3d 169 (D.C. Cir. 2012) 13, 26

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129 F.3d 618 (D.C. Cir. 1997) 12

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407 F.3d 1250 (D.C. Cir. 2005) 44

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565 U.S. 42 (2011) 27, 37

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135 S. Ct. 2480 (2015) 27

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558 U.S. 233 (2010) 35

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504 U.S. 555 (1992) 11

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No. ELH-18-2849, 2019 WL 410424 (D. Md. Feb. 1, 2019) 36

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562 U.S. 44 (2011) 27, 33

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456 U.S. 353 (1982) 28

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786 F.3d 34 (D.C. Cir. 2015) 12

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567 U.S. 519 (2012) 1, 39

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489 F.3d 1279 (D.C. Cir. 2007) 16, 23

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521 U.S. 811 (1997) 11

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610 F.3d 69 (D.C. Cir. 2010) 21, 22

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749 F.2d 788 (D.C. Cir. 1984) 12

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819 F.3d 466 (D.C. Cir. 2016) 13, 26

STATUTES

5 U.S.C. § 553 ..... 43, 44

26 U.S.C. § 36B 5
26 U.S.C. § 5000A 5, 6, 35, 36
26 U.S.C. § 9815 6
29 U.S.C. § 1185d 6
42 U.S.C. §§ 300gg *et seq.* 6
42 U.S.C. § 300gg 4, 7
42 U.S.C. § 300gg-1 4
42 U.S.C. § 300gg-3 34
42 U.S.C. § 300gg-6 5
42 U.S.C. § 300gg-11 5
42 U.S.C. § 300gg-15 7
42 U.S.C. § 300gg-16 6
42 U.S.C. § 300gg-18 7
42 U.S.C. § 300gg-19 7
42 U.S.C. § 300gg-21 6
42 U.S.C. § 300gg-22 7
42 U.S.C. § 300gg-23 7
42 U.S.C. § 300gg-41 ..... 4, 33, 34
42 U.S.C. § 300gg-42 33
42 U.S.C. § 300gg-63 6
42 U.S.C. § 300gg-91 ..... 4, 5, 6, 36
42 U.S.C. § 300gg-92 ..... 27, 30
42 U.S.C. § 18011 ..... 6, 35
42 U.S.C. § 18021 ..... 5, 6
42 U.S.C. § 18022 5

42 U.S.C. § 18031 ..... 5, 6, 7

42 U.S.C. § 18032 ..... 4, 5, 6, 32

42 U.S.C. § 18041 7

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INTRODUCTION

In 2010, Congress enacted the Patient Protection and Affordable Care Act (the "ACA") to "increase the number of Americans covered by health insurance and decrease the cost of health care." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012) ("*NFIB*"). Until recently, however, premiums had sky-rocketed while consumer choices had diminished as many insurers abandoned the individual market. Millions of Americans were forced to purchase one-size-fits-all plans that did not meet their needs or their budgets or they were priced out of the market entirely. A 2016 regulatory measure on short-term, limited duration insurance" ("STLDI") exacerbated these conditions by severely restricting the options for consumers who needed short term coverage.

To facilitate relief for such consumers within the confines established by Congress, the Departments of Labor, Treasury and Health and Human Services (the "Departments") issued a final rule in August 2018 to restore STLDI as a realistic coverage option (the "STLDI Rule"). STLDI policies can be a cost-effective solution to health coverage needs. In 1996, Congress exempted them from the federal regulations governing the individual health insurance market—an exemption that was reaffirmed in 2010 in the ACA. The final STLDI Rule restores the permissible term of an STLDI policy from less than three months (first instituted in 2016) to any period of less than one year, thus reverting to the long-standing framework in effect when Congress enacted the ACA. It additionally caps the total duration of coverage under an STLDI policy, including any renewals or extensions of the initial term, at 36 months, and requires issuers of those policies to notify consumers, among other things, that these policies are not required to comply with the ACA and may include exclusions or limitations that should be carefully evaluated. The Rule also reiterates that states may implement state-appropriate regulations that may impose stricter standards on STLDI, consistent with Congress's longstanding recognition that states are the primary regulators of insurance and that insurance markets are quintessentially local in nature. In allowing states to permit more flexible and cost-effective options for consumers, in particular those who have been priced out of individual market coverage, the rule complements the ACA's goals of increasing affordability, availability, and continuity of health insurance coverage.

Plaintiffs, health advocacy organizations and trade associations of psychiatrists and ACA-regulated insurers, claim that the rule exceeds the Departments' authority, is contrary to law, and is arbitrary and capricious because, *inter alia*, it would permit a parallel individual insurance market not subject to the ACA's consumer protection standards. The argument, however, amounts to a mere policy disagreement with Congress's decision to exempt STLDI from federal regulation of the individual insurance market and fails on both jurisdictional and substantive grounds.

First, Plaintiffs lack standing to pursue their claims. With regard to their claim of standing on behalf of issuers of ACA-regulated health plans, Plaintiffs fail to provide any non-speculative, non-conclusory evidence that any such plan has suffered or will suffer any certainly impending loss of enrollment as a result of the rule. Indeed, Plaintiffs' prediction that the rule, if allowed to take effect, would "inflict serious harm on . . . the health insurance marketplaces" Compl. ¶ 2, has not come to pass. Instead, preliminary data for the 2019 ACA open enrollment indicate that enrollment declined by only 4 percent across states using the federal marketplace platform, a decline that is *smaller* than declines that occurred when Plaintiffs' desired less-than-three months rule was in effect. Moreover, market conditions across different states and regions are highly variable, and whether any specific ACA-regulated plan has lost or will lose any enrollees is dependent on how third-party issuers make decisions in complex and dynamic federal and state regulatory environments. Thus, there is no basis to determine whether a specific insurance company has or will suffer a loss of enrollment or whether such loss is attributable to the rule or one of myriad other factors, such as Congress's reduction of the individual mandate tax penalty to $0, the high premiums of ACA-regulated plans, and the availability of employer-sponsored coverage (at least 2 million more people were employed this year than last year).

Plaintiffs' claim of standing on behalf of consumers and healthcare providers is similarly deficient. Plaintiffs assert that their consumer-members will face higher premiums as a result of the STLDI Rule, but they do not identify a single such member who will pay a higher premium; indeed, 87 percent of consumers who purchase individual health coverage through the ACA Exchanges are generally insulated from the effects of premium increases because they receive

subsidies that are pegged to premiums. Moreover, for the first time since the ACA's enactment, average premiums have stabilized (with a slight decline) for 2019. And whether any unsubsidized consumer may encounter cost increases in 2020 or beyond will turn on numerous unknowable factors regarding the future behavior of third parties, including state regulators, STLDI issuers, ACA-regulated plan issuers, and consumers in different regions across the nation. For these reasons, the D.C. Circuit has rejected an identical theory of standing, holding that consumers of ACA-regulated insurance lacked standing to challenge a Department of Health and Human Services ("HHS") regulatory policy because the many factors that determine the cost of health care rendered speculative the plaintiffs' assumption that the challenged policy would cause rate increases for ACA-regulated plans. *Am. Freedom Law Ctr. v. Obama*, 821 F.3d 44, 49 (D.C. Cir. 2016), *cert. denied*, 137 S. Ct. 1069 (2017). For similar reasons, Plaintiffs' assertion of standing on behalf of providers who fear that they will be required to provide more uncompensated care—because their patients will either be priced out of the ACA insurance market or mistakenly purchase STLDI plans that do not provide necessary coverage—is conjectural and cannot support standing.

Plaintiffs' claims also fail on the merits. Contrary to Plaintiffs' arguments, the Departments clearly had the authority to issue the STLDI Rule because the Rule largely restores the long-standing regulatory definition of STLDI under the Health Insurance Portability and Accountability Act ("HIPAA"), an approach that Congress left intact when enacting the ACA. The Rule is not contrary to law because Congress itself chose to exempt STLDI coverage from the federal individual market requirements and consistently has treated STLDI plans as distinct from individual health insurance coverage, without ever suggesting that STLDI coverage must be restricted in favor of insurance products regulated under the ACA. Nor is the STLDI Rule arbitrary and capricious. The Departments considered the possible adverse effects of the rule on the overall risk pool in the individual market and reasonably determined—as confirmed by many analyses—that those effects are minor and are outweighed by the urgent need to provide relief to consumers who need gap coverage or cannot afford ACA-regulated plans.

STATUTORY AND REGULATORY BACKGROUND

I. HIPAA's Exclusion of "Short-Term Limited Duration Insurance"

In 1996, Congress enacted HIPAA, Pub. L. No. 104-191, 110 Stat 1936. HIPAA, among other things, amended the Public Health Service Act ("PHS Act") to establish federal standards for "individual health insurance coverage." *See* PHS Act § 2741, *codified at* 42 U.S.C. § 300gg-41, *et seq.* Congress defined "individual health insurance coverage" to mean "health insurance coverage offered to individuals in the individual market, but [that] does not include short-term limited duration insurance." PHS Act § 2791(b)(5), *codified* at 42 U.S.C. § 300gg-91(b)(5).

Although HIPAA excluded STLDI plans from its individual market reforms, it did not define what constitutes STLDI. Thus, on April 8, 1997, the Departments published an interim final rule (the "1997 Rule") to define that term as "health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is within 12 months of the date such contract becomes effective." 62 Fed. Reg. 16,894, 16,928 (Apr. 8, 1997). In 2004, the Departments issued a final rule adopting a substantively identical definition without opposition or comment. *See* 69 Fed. Reg. 78,720, 78,748 (Dec. 30, 2004).

II. The ACA's Retention of HIPAA's STLDI Exemption

In 2010, Congress enacted the ACA to implement a series of insurance market changes, including "guaranteed issue" and "community rating" requirements, in the individual and small group markets. "Guaranteed issue" generally requires insurers to offer coverage to all individuals regardless of health status and to accept every individual who applies for such coverage, and "community rating" generally prohibits insurers from charging higher premiums based on a person's medical history or gender. *See* 42 U.S.C. §§ 300gg, 300gg-1. In tandem with these requirements, the ACA requires health insurers to "consider all enrollees in all [individual] plans . . . to be members of a single risk pool[]" and "all enrollees in all [small group] plans . . . to be members of a single risk pool" for purposes of setting their premiums. 42 U.S.C. § 18032(c). The

Act also requires mandatory provision of "essential health benefits" and imposes restrictions on annual and lifetime dollar limits, *id.* §§ 300gg-6, 300gg-11, 18022(b), but did not amend HIPAA's definition of "individual health insurance coverage," thereby retaining the exemption for STLDI plans and extending it to these new requirements. *See id.* § 300gg-91(b)(5).

The ACA further established "Health Benefit Exchanges" or state-based virtual marketplaces where consumers can purchase ACA-compliant "qualified health plans" or "QHPs." *See* 42 U.S.C. §§ 18021, 18031, 18032.[1] To help low-income individuals obtain such coverage, the law provides subsidies in the form of premium tax credits, which are available only to eligible consumers who purchase a QHP through an Exchange. *See generally* 26 U.S.C. § 36B. The amount of this subsidy is pegged to the premium charged by a benchmark plan available on the Exchange, as well as to a consumer's household income. *Id.* § 36B(b)(2). If premiums for the benchmark plan increase, this subsidy increases by a corresponding amount, thus insulating the taxpayer from the effect of the premium increase. Wu Decl. ¶ 6. In 2018, roughly 87 percent of consumers purchasing insurance through an Exchange received this subsidy. *Id.*

QHPs sold on an Exchange qualify as one of several forms of "minimum essential coverage" identified by the Act. 26 U.S.C. § 5000A(f)(1)(C). As enacted, the Act required applicable individuals to maintain "minimum essential coverage"—commonly referred to as the "individual mandate"—or pay a tax penalty, unless the individual qualifies for one of several enumerated exemptions, *id.* § 5000A(a)-(b), such as when an individual cannot afford ACA-compliant coverage or will suffer hardship with respect to obtaining such coverage. *Id.* § 5000A(e)(1), (5). In December 2017, Congress enacted the Tax Cuts and Jobs Act of 2017 ("TCJA"), which reduced the amount of the tax penalty to $0 for all individuals effective January 1, 2019. *See* Budget Fiscal Year, 2018, Pub. L. No. 115-97 § 11081, 131 Stat 2054 (2017).

[1] As used in this brief, "ACA-compliant" and "ACA-regulated" are terms of art that refer to health insurance plans in the individual and small group market that are required to conform to the ACA's guaranteed issue, community rating, and single risk pool requirements, as contrasted to STLDI and other health coverage products not subject to those requirements.

The ACA also includes other provisions designed to encourage individuals to enroll in QHPs through an Exchange. For example, it provides that if a taxpayer is not enrolled in minimum essential coverage, the Internal Revenue Service must notify the taxpayer of the services available through the Exchange in that taxpayer's state. 42 U.S.C. § 18092. The Act also created a "Navigators" program, which allocates federal funds to help consumers search for health coverage options through an Exchange and to "facilitate enrollment in" QHPs, 42 U.S.C. § 18031(i)(3).

Notably, however, the ACA does not require all forms of health coverage to be a QHP; indeed, only about 3 percent of the American population obtained individual market QHP coverage through an Exchange in 2017. Wu Decl. ¶ 8. Non-QHP coverage options that are not subject to the ACA's "single risk pool" requirements and are at least partially exempt from other ACA requirements include:

- Insurance policies and group health plan coverage in effect prior to the ACA's enactment (also known as "grandfathered health plans"), *see* 42 U.S.C. § 18011;
- Student health insurance plans, *see* 42 U.S.C. § 18118(c); 45 C.F.R. § 147.145;
- Large group market coverage, and self-insured group health plans, which are arrangements in which an employer collects contributions from its employees and takes on the responsibility of paying medical claims, which together make up the largest portion of the health coverage markets, *see* Wu Decl. ¶ 8; 42 U.S.C. §§ 300gg-16, 18021(b)(1)(B), 18063; 29 U.S.C. § 1185d(b); 26 U.S.C. § 9815(b);
- Government-sponsored health coverage, *see* 42 U.S.C. §§ 300gg-21(a), 18032(c) (defining scope of ACA reforms);
- Health care sharing ministries, or organizations that facilitate sharing of health care costs among individual members with common ethical or religious beliefs, *see* 42 U.S.C. § 300gg *et seq.* (defining scope); *cf.* 26 U.S.C. § 5000A(d)(2)(B); and
- "Excepted benefits," such as policies that protect against certain accidents or provide limited benefits, such as dental or vision benefits, benefits for certain types of disease, and long-term care, *see* 42 U.S.C. §§ 300gg-21(b)-(c), 300gg-63(b).

STLDI plans, too, are excluded from the ACA's individual market insurance reforms by virtue of Congress's exclusion of such plans from the definition of "individual health insurance coverage." 42 U.S.C. § 300gg-91(b)(5). By allowing these other forms of health coverage vehicles

to co-exist with ACA-compliant coverage, and by permitting certain exemptions from the individual mandate, Congress recognized that ACA-complaint coverage will not be appropriate in every circumstance.

Finally, although the ACA greatly expanded the role of the federal government in the regulation of health insurance, Congress indicated through various provisions in the ACA that states should remain the primary regulators of health insurance. Indeed, under the ACA, states have the flexibility to implement the Act in state-specific ways and the authority to enforce many of the Act's individual market reforms. *See* 42 U.S.C. §§ 300gg-22, 300gg-23, 18041. The ACA also directs HHS to consult with the National Association of Insurance Commissioners ("NAIC") in developing standards to implement the statute, in due recognition of state regulators' expertise in formulating insurance policies appropriate for their respective states. *See, e.g.*, 42 U.S.C. §§ 18031(c)(1)(F), 18041(a)(2), 300gg(a)(3), 300gg-15(a), 300gg-18(c); 300gg-19(b)(1).

III. The 2016 STLDI Rule

Premiums for health plans sold in the individual market rose drastically after the ACA's insurance market reforms took effect in 2014. Between 2013 and 2014, premiums rose an average of roughly 38 percent; between 2014 and 2015, they rose another 23 percent.[2] During that time, higher-than-expected health care costs drove many issuers to exit the individual health insurance markets, leaving consumers with fewer and less affordable insurance choices.[3]

On October 31, 2016, the Departments adopted a final rule (the "2016 Rule") to, among other things, reduce the maximum term and duration of an STLDI plan from less than twelve months (under the 1997 and 2004 Rules) to less than three months. 81 Fed. Reg. 75,316, 75,317-

[2] *See, e.g.*, Forbes, Overwhelming Evidence that Obamacare Caused Premiums to Increase Substantially (July 28, 2016), https://www.forbes.com/sites/theapothecary/2016/07/28/overwhelming-evidence-that-obamacare-caused-premiums-to-increase-substantially/#61242bf715be (last visited Feb. 21, 2019).

[3] *See, e.g.*, The Brookings Institution & The Rockefeller Institute, A Study of Affordable Care Act Competition in Texas (Feb. 2017), https://www.brookings.edu/wp-content/uploads/2017/02/texas-aca-competitiveness-2-6-for-print.pdf (last visited Feb. 21, 2019).

19 (Oct. 31, 2016). The Departments explained that they believed the change was warranted because "[i]n some instances, individuals are purchasing [STLDI] coverage as their primary form of health coverage and . . . some issuers are providing renewals of the coverage that extend the duration beyond 12 months[,]" which could "adversely impact[] the risk pool for Affordable Care Act-compliant coverage." *Id.* at 75,317-18. The NAIC, among others, opposed the 2016 Rule, observing that it was likely to harm consumers and "have little positive impact on the risk pools in the long run." NAIC Comment, 2016 Proposed Rule (Aug. 9, 2016), at 1-2.[4] Nevertheless, the Departments finalized the 2016 Rule, effective January 1, 2017.

IV. The 2018 STLDI Rule

Market conditions in the Exchanges continued to deteriorate after the 2016 Rule took effect. The nationwide average Exchange enrollment among unsubsidized consumers in the individual market declined by 1.3 million, or 20 percent, between 2016 and 2017. STLDI, Final Rule, 83 Fed. Reg. 38,212, 38,214 (Aug. 3, 2018), A.R.14; *see also* Comment, Galen Institute, at 2 (Apr. 23, 2018), A.R.196342 ("between a third and a half of people ages 45 to 59 and a quarter of those 60+ went without needed health care in the last year due to its costs").[5] During the same period, average Exchange enrollment in the individual market decreased by 10 percent and premiums increased by 21 percent. 83 Fed. Reg. at 38,214. Between 2017 and 2018, individual market premiums rose again, this time by 37 percent. *Id.* at 38,232. Further, in 2018, more than half of counties had access to just one individual market issuer in the Exchange. *Id.* at 38,234.

On January 20, 2017, the President issued an Executive Order directing all agencies with authority and responsibilities under the ACA, to the extent permitted by law, to provide relief from "regulatory burden[s] on individuals, families, health care providers, health insurers, patients," and other stakeholders in order to "encourage the development of a free and open market . . . for the

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[4] https://www.naic.org/documents/government_relations_160809_hhs_reg_short_term_dur_plans.pdf (last visited Feb. 21, 2019).

[5] Citations to the Administrative Record are referred to with the prefix "A.R."

offering of health care services and health insurance, with the goal of achieving and preserving maximum options for patients and consumers." Exec. Order No. 13,765, Minimizing the Economic Burden of the [ACA] Pending Repeal, 82 Fed. Reg. 8351, Sec. 4 (Jan. 20, 2017).

On June 12, 2017, HHS published a request for information from interested parties "on changes that could be made, consistent with current law, to existing regulations . . . that would result in a more streamlined, flexible, and less burdensome regulatory structure" under the ACA. 82 Fed. Reg. 26,885, 26,886, A.R.48. In response, HHS received feedback that the "shortening of the permitted length of [STLDI] policies [under the 2016 Rule] had deprived individuals of affordable coverage options," especially for "financially-stressed individuals [who] may be faced with a choice between [STLDI] coverage and going without any coverage at all." STLDI Rule, 83 Fed. Reg. at 38,213, A.R.13.

On October 12, 2017, the President issued another executive order directing the Departments to prioritize efforts to expand the availability of STLDI, among other things. *See generally* Exec. Order No. 13813, Promoting Healthcare Choice and Competition Across the United States, 82 Fed. Reg. 48,385 (Oct. 12, 2017). On February 21, 2018, the Departments issued a proposed rule to restore the maximum term of STLDI policies to less than twelve months. The Departments also proposed an expanded consumer notice requirement for STLDI plans and solicited comment on the proposed STLDI definition. Short-Term, Limited-Duration Insurance, Proposed Rule ("STLDI Proposed Rule"), 83 Fed. Reg. 7437 (Feb. 21, 2018). The Departments received approximately 12,000 comments. NAIC, for example, opined that "[r]eturning the Federal definition to 'less than 12 months' . . . is consistent . . . with longstanding federal law [and] how this term has been long defined by most states." A.R.197480. Several states also individually expressed strong support, *see* A.R.196312 (Iowa); A.R.197450 (Montana); A.R.200606 (Alaska), as did the National Association of Insurance and Financial Advisors ("NAIFA"), A.R.190624, among numerous others. *See, e.g.*, A.R.181631; A.R.181650; A.R.181693; A.R.181790; A.R.182209; A.R.182216; A.R.181538; A.R.181546; A.R.181552; A.R.181563.

On August 3, 2018, the Departments finalized the proposed rule with some modifications.

Under the final STLDI Rule, "short-term, limited-duration insurance" means "health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract that is less than 12 months after the original effective date of the contract and, taking into account renewals or extensions, has a duration of no longer than 36 months in total." 83 Fed. Reg. at 38,214-15. The Rule thereby aligns the maximum initial contract term of an STLDI policy with the definition that existed in 2010 when Congress enacted the ACA, while capping the total duration of STLDI coverage, including renewals or other extensions, at 36 months. The Rule also expands the prior requirement that STLDI issuers advise consumers that STLDI coverage is not required to comply with ACA insurance market requirements and may contain important limitations and exclusions, such as the exclusion of coverage for preexisting conditions. The new notice warns consumers that the coverage may not cover specific health benefits, "such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services" and that enrollees might find themselves without coverage if the plan "expires or you lose eligibility for . . . coverage[.]" *Id*. at 38,215.

The STLDI Rule took effect on October 2, 2018. *Id.* at 38,212.

STANDARD OF REVIEW ON SUMMARY JUDGMENT

In actions under the APA, summary judgment is the mechanism for "deciding, as a matter of law, whether the agency action is supported by the administrative record and otherwise consistent with the APA standard of review." *Oceana, Inc. v. Locke*, 831 F. Supp. 2d 95, 106, (D.D.C. 2011). In such cases, the standard set forth in Rule 56 of the Federal Rules of Civil Procedure "does not apply because of the limited role of a court in reviewing the administrative record." *Forest Cty. Potawatomi Cmty. v. United States*, 330 F. Supp. 3d 269, 278 (D.D.C. 2018) (citation omitted). Rather, "a federal district court sits as an appellate tribunal to review the purely legal question of whether the agency acted" reasonably and otherwise in accordance with the APA. *Franks v. Salazar*, 816 F. Supp. 2d 49, 55-56 (D.D.C. 2011) (citation omitted).

Review under the APA is "highly deferential" and begins with a presumption that the agency's actions are valid. *Envtl. Def. Fund, Inc. v. Costle*, 657 F.2d 275, 283 (D.C. Cir. 1981).

Judicial review is limited to the administrative record, and the burden is on the plaintiff to prove that the agency's decision is inconsistent with the APA. *Id.* The court is "not empowered to substitute its judgment for that of the agency," *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416 (1971), but instead must consider only "whether the agency acted within the scope of its legal authority, whether the agency has explained its decision, whether the facts on which the agency purports to have relied have some basis in the record, and whether the agency considered the relevant factors[.]" *Fulbright v. McHugh*, 67 F. Supp. 3d 81, 89 (D.D.C. 2014).

ARGUMENT

I. Plaintiffs' Claims Fail for Lack of Subject Matter Jurisdiction.

At the outset, the Court lacks jurisdiction over this dispute because Plaintiffs have not demonstrated Article III standing. "[N]o principle is more fundamental to the judiciary's proper role in our system of government than the constitutional limitation of federal-court jurisdiction to actual cases or controversies." *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 408 (2013). One element of this constitutional limitation is that a plaintiff must establish that he has standing to sue. *Raines v. Byrd*, 521 U.S. 811, 818 (1997). The requirement is "built on separation-of-powers principles" and "serves to prevent the judicial process from being used to usurp the powers of the political branches." *Clapper*, 568 U.S. at 408.

The "irreducible constitutional minimum" of standing requires a plaintiff to demonstrate an injury-in-fact that is: (1) concrete and particularized, and actual or imminent, not conjectural or hypothetical, (2) fairly traceable to the challenged conduct of the defendant, and (3) likely to be redressed by a favorable judicial decision. *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560-61 (1992). "In requiring a particular injury, the Court mean[s] 'that the injury must affect the plaintiff in a personal and individual way.'" *Ariz. Christian Sch. Tuition Org. v. Winn*, 563 U.S. 125, 134 (2011) (citation omitted). The Supreme Court has also "repeatedly reiterated that 'threatened injury must be *certainly impending* to constitute injury in fact,' and that 'allegations of *possible* future injury' are not sufficient." *Clapper*, 568 U.S. at 409 (citation omitted); *see also Lujan*, 504 U.S. at 564 n.2 (plaintiff who "alleges only an injury at some indefinite future time" has not shown an injury

in fact; "the injury [must] proceed with a high degree of immediacy, so as to reduce the possibility of deciding a case in which no injury would have occurred at all"). These requirements ensure that legal questions are "resolved, not in the rarified atmosphere of a debating society, but in a concrete factual context conducive to a realistic appreciation of the consequences of judicial action." *Valley Forge Christian Coll. v. Ams. United for Separation of Church & State, Inc.*, 454 U.S. 464, 472 (1982).

A plaintiff "bears the burden of showing that he has standing for each type of relief sought." *Summers v. Earth Island Inst.*, 555 U.S. 488, 493 (2009). To meet that burden at the summary judgment stage, a plaintiff "must support each element of its claim to standing by affidavit or other evidence[.]" *Sierra Club v. EPA*, 292 F.3d 895, 899 (D.C. Cir. 2002) (citations omitted).[6] Under the doctrine of associational standing, an organizational plaintiff may satisfy these requirements by showing, among other things, that at least one of its members satisfies the standing requirements. *Nat'l Ass'n of Home Builders v. EPA*, 786 F.3d 34, 40 (D.C. Cir. 2015).

A. Plaintiffs Fail to Establish Standing on Behalf of Their Insurer-Members.

1. Plaintiffs Have Not Shown that Any Insurer Member Will Lose Enrollees to STLDI Plans.

Plaintiff Association for Community Affiliated Plans ("ACAP"), a trade association of health insurers, Compl. ¶ 19, claims that sixteen of its members who sell individual policies on the ACA Exchanges will "lose customers to competing companies offering STLDI policies" as a result of the Rule, *id*. ¶ 23. Plaintiffs focus on one ACAP member in particular, the Texas-based Community Health Choice, Inc. ("CHC"), which sells ACA-compliant plans in eight counties in the Houston area.[7] CHC enrolled roughly 106,000 low-income enrollees through the Texas

[6] Although APA review on the merits is based solely on the administrative record, *IMS, P.C. v. Alvarez*, 129 F.3d 618, 623 (D.C. Cir. 1997), the Court may consider materials outside the record to decide whether Plaintiffs have standing. *See Walter O. Boswell Mem'l Hosp. v. Heckler*, 749 F.2d 788, 794 (D.C. Cir. 1984).

[7] Plaintiffs have provided very little information about the remaining fifteen insurers for which ACAP claims associational standing, *see* Pls.' Reply Mem. in Supp. of Prelim. Inj. ("PI Reply"), at 2-3 n.2, ECF No. 25; Supp. Murray Decl. at Tables 1 and 2, ECF No. 26-1, likely because they

Exchange in 2018 and has speculated that the STLDI Rule could cause it to lose "as many as" 10,000 (or roughly 9 percent) of its ACA enrollees to STLDI plans in the future. *Id.* ¶¶ 24-30; Pls.' Mem. in Support of Mot. for Prelim. Inj. ("PI Mot.") at 33-34, ECF No. 10-1; Decl. of Kenneth Janda in Supp. of PI Mot. ("Janda PI Decl.") ¶¶ 6, 11, ECF No. 10-6, Supp. Decl. of Margaret Murray in Supp. of PI Mot. ("Murray Supp. PI Decl."), Table 2, ECF No. 10-10. Plaintiffs must do more, however, to support the alleged certainly impending harm, because whether CHC will lose enrollees to the STLDI market depends on a number of state-specific, market-specific, and product-specific factors reflecting a broad array of choices by independent actors that are not before the Court. For example, how the state of Texas regulates STLDI plans could have an impact on enrollment. Indeed, in contrast with what is permissible under the Rule, Texas does not permit extensions or renewals of an STLDI plan beyond one year, *see* 28 Tex. Admin. Code § 3.3002(18), and at a minimum, CHC will not be harmed by, and does not have standing to challenge, the STLDI Rule's 36-month renewability provision. Other market-specific factors include whether STLDI insurers sell their plans in the Houston counties served by CHC, whether the mix of benefits offered by those plans is attractive to CHC's enrollees, whether CHC's enrollees could pass any underwriting requirements imposed by the STLDI plans, and how the premiums charged by the STLDI plans compare to CHC's premiums and the premiums of other ACA-compliant issuers after accounting for any subsidies that CHC's members receive if they purchased individual market coverage through the Texas Exchange. The law is clear that standing may not be premised on "an extended chain of contingencies[,]" *Williams v. Lew*, 819 F.3d 466, 473 (D.C. Cir. 2016), especially those that "depend[] on the acts of third parties not before the court," *Grocery Mfrs. Ass'n v. EPA*, 693 F.3d 169, 176 (D.C. Cir. 2012); *see also DEK Energy Co. v. FERC*, 248 F.3d 1192, 1194-95

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cannot demonstrate the requisite "certainly impending" injury as a result of the STLDI Rule. Indeed, at least six of these members do business in states in which no STLDI policies were available as of January 2019. *See* PI Reply at 2-3 n.2 (listing six insurer members in California, Massachusetts, New York, and Rhode Island); HealthInsurance.org, *Current State Regulations*, https://www.healthinsurance.org/so-long-to-limits-on-short-term-plans/#current (last visited Feb. 21, 2019) (describing state-level regulation limiting or banning STLDI in those states).

(D.C. Cir. 2001) (no standing despite allegation that government action increased competitors' "*ability* to sell profitably in [plaintiff's] areas" and "the *probability* of such entry").

In fact, the evidence that does exist undercuts CHC's assertions of injury. Plaintiffs claim that CHC serves a predominantly low-income population, Compl. ¶ 24; Janda PI Decl. ¶ 8, which is likely eligible to receive subsidies toward the cost of CHC's premiums. Indeed, 86 percent of Texans enrolling in plans through the Texas Exchange received such subsidies in 2018,[8] and many of those consumers could purchase an Exchange plan in 2019 for little to no out-of-pocket premium costs.[9] Not only would these customers be unable to apply the subsidies to purchase STLDI coverage, they also generally would be insulated from the effects of any price increases that may be caused by the STLDI Rule if they retain their ACA-compliant coverage through the Texas Exchange. Wu Decl. ¶ 6. These circumstances leave little incentive for CHC's low income customers to switch to an STLDI plan.

Moreover, even if CHC's ACA-compliant plans are more expensive than STLDI for a fraction of CHC's consumers,[10] it is far from clear that those enrollees would switch to such

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[8] *See* https://www.healthinsurance.org/texas-state-health-insurance-exchange/ (last visited Feb. 21, 2019); *see also* Supp. Murray Decl. Table 2, ECF No. 26-1.

[9] The Kaiser Family Foundation ("KFF")—whose research is well respected in the field—reports that this is true, for example, in Harris, Fort Bend, and Montgomery Counties (all served by CHC), where subsidy recipients, depending on income bracket, can obtain a Bronze plan in 2019 for as low as $0 or $12 per month. *See* KFF, *Some Can Get Marketplace Plans With No Premiums, Though With Higher Deductibles & Cost Sharing*, https://www.kff.org/health-costs/press-release/some-can-get-marketplace-plans-with-no-premiumsthough-with-higher-deductibles-and-cost-sharing/ (last visited Feb. 21, 2019); *see also* Robert Pear, Despite Challenges, Health Exchange Enrollment Falls Only Slightly, The New York Times (Dec. 19, 2019) (reporting that "[i]n many counties, people of modest means could get insurance for free [in 2019], as federal subsidies would pay the entire premium for some policies."), https://www.nytimes.com/2018/12/19/us/politics/obamacare-enrollment.html (last visited Feb. 21, 2019).

[10] Despite claiming to serve a low-income population, CHC also states that roughly one-third of its enrollees receive "limited or no subsidies[.]" Compl. ¶ 25. CHC does not, however, quantify what it means by "limited" or specify what proportion of its enrollees receives no subsidies. In general, any amount of subsidies, even if limited in amount, would help insulate an enrollee against any price increases that may be caused by the STLDI Rule. Wu Decl. ¶ 6. For these reasons, the

coverage based solely on its lower price tag, given the many differences between STLDI and ACA-compliant plans. In fact, CHC itself has asserted that STLDI products "are not reasonable alternatives for the vast majority of [its] members" because "many have pre-existing conditions, and few can afford large deductibles." Janda PI Decl. ¶ 8. If so, the vast majority of CHC's enrollees are unlikely to switch to STLDI. And to the extent CHC speculates that unscrupulous marketers of STLDI plans nevertheless could "lure" enrollees away in spite of the transparency notifications required by the STLDI rule, Compl. ¶¶ 6, 27, that concern is dependent on the supposed misconduct or mistakes of third parties, and cannot form the basis of CHC's standing.

As support for their theory, Plaintiffs have relied on "the government estimates that enrollment in ACA-compliant plans will decrease by 200,000 people in 2019, and that enrollment will be down by 1.3 million by 2028." PI Mot. at 34 (citing 83 Fed. Reg. at 38,236). However, the cited analysis, which was performed by CMS's Office of the Actuary ("OACT"), assessed the likely impact of the STLDI Rule *nationwide* and provides no information at all regarding the particular plaintiffs in this litigation or their members, not to mention that the projected decline was expected to occur predominantly among unsubsidized enrollees. *See* 83 Fed. Reg. at 38,236.[11] *Cf. Am. Freedom Law Center*, 821 F.3d at 49 (concluding that plaintiffs' claim of standing was "speculative" because although the insurer's rate filings indicated that average premiums initially increased due to the HHS policy at issue, they did not demonstrate that premiums for any particular plan would increase or would remain higher over time). Other analyses, including an estimate performed by the Congressional Budget Office ("CBO") and an estimate performed by the Wakely

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Congressional Budget Office ("CBO") projected that less than one percent of subsidized enrollees will switch coverage as a result of the STLDI Rule. *See* CBO, How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short Term Plans, at Table 1 (Jan. 2019) ("CBO 2019 Report") (predicting that only 50,000 of 6.9 million subsidized enrollees would switch to an STLDI plan), https://www.cbo.gov/system/files?file=2019-01/54915-New_Rules_for_AHPs_STPs.pdf (last visited Feb. 21, 2019).

[11] *See generally* CMS, Office of the Actuary, Estimated Financial Effects of the Short-Term, Limited-Duration Policy Proposed Rule (Apr. 6, 2018) ("OACT Estimate"), https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/STLD20180406.pdf (last visited Feb. 21, 2019).

Group for Plaintiff ACAP, are no different. *See generally* CBO, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028*, 12 (May 23, 2018) ("CBO 2018 Report"); Murray Decl. in Supp. of PI Mot., Ex. B, ECF No. 10-10 (the "Wakely Report").

As the Departments have cautioned, "there is significant uncertainty regarding all of these estimates," because "it is difficult to predict how consumers and issuers will react to the policy changes finalized in this rule" and "the impact [of the STLDI Rule] in any given state will vary depending on state regulations and the characteristics of that state's markets and risk pools." STLDI Rule, 83 Fed. Reg. at 38,237, 38,239. The cited analyses thus themselves underscore the fact that the actual impact is inherently uncertain. The OACT Estimate provides that its projections were "inherently uncertain." OACT Estimate at 3. The CBO likewise observed that "[t]he ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other parties will behave in the future are all difficult to predict, so the estimates in this report are uncertain." 2018 CBO Report at 19. In a follow-up report, CBO further explained that its projections "represent the middle of an extremely broad range of possible outcomes[,]" and the "short-term plans that insurers will actually offer—and the premiums that they charge—may differ considerably from those" modeled, which "would affect enrollment in the new plans, the characteristics of the enrollees that those plans attract, and the resulting effects on the . . . small-group and nongroup markets." 2019 CBO Report at 9-10. These types of broad-stroke projections may be appropriate to guide policymaking, but they cannot by themselves establish an Article III injury. *Cf. United Transp. Union v. ICC*, 891 F.2d 908, 915-16 (D.C. Cir. 1989) (holding that legislative projections about the effects of a particular policy did not demonstrate Article III standing because "there is no constitutional requirement that such [projections] . . . be correct, or even likely, for Congress to legislate in reliance on them," whereas a "court's . . . inquiry is much more rigorous"); *Pub. Citizen, Inc. v. NHTSA*, 489 F.3d 1279, 1294 (D.C. Cir. 2007) ("[T]he 'law of averages is not a substitute for standing.'").

That is especially true here, where initial projections regarding the *potential* impact of the STLDI Rule have been overtaken by *actual data* suggesting that the STLDI Rule has not impacted

markets in the way Plaintiffs claim. Plaintiffs' early predictions that the STLDI Rule would cause millions to drop their ACA-compliant coverage in 2019 and precipitate a "death spiral" for ACA compliant plans, PI Mot. at 19; Compl. ¶ 4, have not been borne out. Instead, preliminary data indicate that 2019 enrollment declined only slightly, by approximately 332,000 enrollees (or roughly 3.8 percent) across the 39 states that use the Healthcare.gov platform and by roughly 3.8 percent in Texas, which is significantly *less* than enrollment declines in recent years. Wu Decl. ¶ 20.[12]

2. Plaintiffs Have Not Shown that the Alleged Injury Is Traceable to the STLDI Rule or Redressable Through Its Invalidation.

Even if Plaintiffs were able to submit evidence of CHC's decreased enrollment for 2019, such evidence would not by itself demonstrate that the decrease is due to the STLDI Rule. As the D.C. Circuit has recognized, because of the inherently variable nature of health insurance coverage and cost, a plaintiff must provide more than "[m]ere unadorned speculation as to the existence of a relationship between the challenged government action [*i.e.*, the STLDI Rule] and the third-party conduct [*i.e.*, consumers' decision not to enroll in CHC's plans]." *Am. Freedom Law Ctr.*, 821 F.3d at 49 (citation omitted). Plaintiffs face an uphill battle establishing such traceability and redressability here. Five states that enacted regulations consistent with the regulatory approach preferred by Plaintiffs (either limiting STLDI to less than three months or banning it altogether)—New Jersey, Washington, Oregon, Delaware, and California—each saw enrollment *declines* in enrollment in QHPs in 2019, notwithstanding their restrictive approach to STLDI.[13] Conversely,

[12] *See also* Pear, *supra* note 9 (reporting "a drop of about 367,000 or 4 percent, despite warnings that a more precipitous drop could be in the offing" and citing former Healthcare.gov official opinion that "the number of people renewing coverage . . . this year was impressive"); Alice Ollstein *et al.*, Obamacare sign-ups see late surge, Politico (Dec. 19, 2018) (ACA enrollment remained "relatively stable" for 2019); Katie Keith, HealthCare.gov Enrollment Down Only Slightly, HealthAffairs (Dec. 21, 2018) ("enrollment through HealthCare.gov remained stable" in 2019), https://www.healthaffairs.org/do/10.1377/hblog20181221.890621/full/#.XFUG2NBoqtk.email

[13] *See* Wu Decl. ¶ 21; *see also* Pear *supra* note 9 (noting that New Jersey, which "banned short-term plans and adopted its own version of the individual insurance mandate[] . . . still had an 8

three states—Florida, Mississippi, and Wyoming—saw enrollment *gains*, despite allowing STLDI up to the full length permitted by the STLDI Rule. Wu Decl. ¶ 22. Enrollment also was roughly stable in several other states that permit STLDI policies of approximately one year, such as Utah, South Carolina, and Nebraska. *Id.* These figures undermine the notion that the expansion of STLDI plans is driving enrollment trends in QHPs in 2019.

Additionally, there are other likely explanations for the enrollment declines in 2019. First, employment across the 39 states for which comprehensive data is available increased by two million in 2018.[14] Given that 90 percent of workers are employed by firms that offer health benefits, many of the roughly 400,000 enrollees that dropped Exchange coverage in 2019 are likely now obtaining employer-sponsored coverage, not STLDI. *Id.*

Second, Congress's recent reduction of the individual mandate tax penalty to $0, effective January 1, 2019, indisputably reduced consumer incentive to purchase ACA-compliant insurance, especially for those who feel they cannot afford it. And, notably, at least one of the analyses on which Plaintiffs previously relied in their preliminary injunction motion, *see* PI Mot. at 33-34, measured the *combined* effect of the reduction of the tax penalty to $0 and the STLDI Rule, and found that the impact of the STLDI Rule, standing alone, was minimal. *See* 83 Fed. Reg. at 38,237-39; Commonwealth Fund at 16-17. The result is not surprising because, as the Departments found,

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percent drop in the number of people signing up for marketplace coverage this fall"); Ollstein, *supra* note 23 (noting that the state of Washington "saw sign-ups drop by nearly 10 percent"); Marjie High, Covered California reports new ACA enrollments down, State of Reform (Jan. 31, 2019) (reporting enrollment drop in California of .5 percent), https://stateofreform.com/featured/2019/01/covered-california-reports-new-aca-enrollments-down/; *see also* KFF, Marketplace Enrollment, 2014-2019 ("KFF Enrollment Tool") (providing state-by-state enrollment figures by year), https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/?currentTimeframe=1&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; Louise Norris, Is short-term health insurance right for you? (Jan. 15, 2019) ("State STLDI Laws") (compiling state-specific regulatory approaches to STLDI), https://www.healthinsurance.org/short-term-health-insurance/.

[14] *See* CMS News, Enrollment Through Federal Exchange Remains Steady (Dec. 19, 2018).

the type of enrollee most likely to switch from an ACA-compliant plan to an STLDI plan is a healthier one who, without a tax penalty, may choose to go without insurance altogether. *See* 83 Fed. Reg. at 38,235. Another recent analysis by the Brookings Institution similarly concluded that the increase in insurance enrollment among the unsubsidized population since the ACA's market reforms took effect are fully attributable to the individual mandate and ACA-related outreach and advertising.[15] Consistent with these findings, a Commonwealth Fund tracking survey recently found that "9 percent of [adults] who got their insurance through the individual market . . . intended to drop insurance because of the" reduction of the mandate penalty in 2019.[16] These studies suggest that the tax reform, not the STLDI Rule, is causing the decline in enrollment.

Third, until recently, premiums for ACA-compliant coverage had risen by double digits from year to year, leading many to seek alternative forms of coverage—such as health care sharing ministries, fixed indemnity plans, direct provider agreements, and "4-packs" of shorter-term STLDI policies under the 2016 STLDI Rule—*well before* the STLDI Rule became effective.[17] As noted above, average monthly enrollment in individual market plans decreased by 10 percent

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[15] Matthew Fiedler, How Did the ACA's Individual Mandate Affect Insurance Coverage? USC-Brookings Schaeffer Initiative for Health Policy (May 2018), at 2, https://www.brookings.edu/wp-content/uploads/2018/05/coverageeffectsofmandate2018.pdf (last visited Feb. 13, 2019).

[16] Sara R, Collins, Munira Z. Gunja, Michelle M. Doty, and Harman K Bhupal, First Look at Health Insurance Coverage in 2018 Finds ACA Gains Beginning to Reverse (May 1, 2018), https://www.commonwealthfund.org/blog/2018/first-look-health-insurance-coverage-2018-finds-aca-gains-beginning-reverse. The Commonwealth Fund analysis also found that ACA enrollment had begun to decline well before the STLDI Rule was published. *Id.*

[17] *See* STLDI Rule, 83 Fed. Reg. at 38,239 ("[STLDI] is already available and can be purchased as four separate less than 3-month insurance policies" (citation omitted)); KFF, Data Note: *Changes in Enrollment in the Individual Health Insurance Market* ("*Enrollment Changes*") (positing that "people who have dropped off-exchange coverage . . . may have obtained coverage elsewhere (e.g., through employer plans, or health care sharing ministries"); https://www.kff.org/health-reform/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market/; John Goodman, Alternatives to Obamacare, Forbes (Jan. 30, 2019) ("[l]arge numbers of Americans are turning to alternatives to Obamacare," including limited benefit indemnity plans and healthcare sharing ministries), https://www.forbes.com/sites/johngoodman/2019/01/30/alternatives-to-obamacare/#76ed4cd061ff.

between 2016 and 2017,[18] and by an additional 12 percent between the first quarter of 2017 and the first quarter of 2018.[19] In Texas specifically, Exchange enrollment declined 13.7 percent between 2016 and 2018[20] due to escalating premiums.[21] Plaintiffs therefore cannot show a substantial probability that any enrollment declines in 2019 for their insurance issuers are fairly traceable to the STLDI Rule.

For many of the same reasons, Plaintiffs also cannot show that a ruling in their favor will redress any loss of enrollment that CHC or ACAP's other members may have experienced. Among other things, many alternative forms of coverage exist, and consumers may continue to choose

[18] *See* STLDI Rule, 83 Fed. Reg. at 38,214; *see also* CMS, Trends in Subsidized and Unsubsidized Individual Health Insurance Market Enrollment ("CMS Trends") (July 2, 2018), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-2.pdf.

[19] *See* KFF, Enrollment in the Individual Insurance Market Continued to Fall in the First Quarter of 2018, With the 12 Percent Overall Decline Concentrated in Off-Exchange Plans (July 31, 2018), https://www.kff.org/health-reform/press-release/enrollment-in-the-individual-insurance-market-continued-to-fall-in-the-first-quarter-of-2018-with-the-12-percent-overall-decline-concentrated-in-off-exchange-plans/.

[20] Louis Norris, Texas health insurance marketplace: history and news of the state's exchange, healthinsurance.org (Dec. 16, 2018), https://www.healthinsurance.org/texas-state-health-insurance-exchange/#enrollment; *see also* Wu Decl. ¶ 20 (providing total enrollment decline figures for 2016 through 2018).

[21] *See, e.g.*, KFF, Poll: Affording Health Care Tops Texans' Financial Concerns (July 10, 2018) (reporting that half of "non-elderly uninsured Texans say that the main reason they don't have coverage is because it is too expensive and unaffordable"); https://www.kff.org/health-costs/press-release/poll-health-care-texans-financial-concerns-almost-4-in-10-problems-paying-medical-bills/; KFF, *Enrollment Changes*, *supra* note 17 (noting that "states that had larger premium increases saw larger declines in unsubsidized ACA-compliant enrollment . . . suggesting a relationship between premium hikes and enrollment drops"); Edmund F. Haislmaier, *Issue Brief: 2017 Health Insurance Enrollment: Little Net Change, But Large Drop in Non-Group Coverage*, The Heritage Foundation (Oct. 30, 2018) (noting large enrollment declines in 2017 and 2018 and concluding that "any take-up of alternative coverage under the Trump Administration's regulatory changes is more likely to be by those who have already abandoned costly Obamacare-compliant plans than by those still buying them"), https://www.heritage.org/health-care-reform/report/2017-health-insurance-enrollment-little-net-change-large-drop-non-group.

them over ACA-compliant coverage, even if Plaintiffs were to prevail here.[22]

3. The Competitor Standing Doctrine Does Not Apply.

The "competitor standing" doctrine does not obviate Plaintiffs' burden under Article III. Under this doctrine, the D.C. Circuit has recognized that "economic actors 'suffer [an] injury in fact when agencies lift regulatory restrictions on their competitors or otherwise allow increased competition' against them." *Sherley v. Sebelius*, 610 F.3d 69, 72 (D.C. Cir. 2010) (citations omitted). The doctrine is a narrow one: "Because of the generally contingent nature of predictions of future third-party action," a court should be "sparing in crediting claims of anticipated injury by market actors and other parties alike." *Arpaio v. Obama*, 797 F.3d 11, 23 (D.C. Cir. 2015). A plaintiff must demonstrate that the government has lifted a "regulatory restriction *on a 'direct and current competitor*'" or taken regulatory action that predictably "enlarges the pool of competitors . . . *in the same market*." *Id.* (emphasis added, citation omitted); *accord New World Radio, Inc. v. FCC*, 294 F.3d 164, 170 (D.C. Cir. 2002). Importantly, the doctrine does not apply when an agency action "is, at most, the first step in the direction of future competition." *New World Radio*, 294 F.3d at 172; *see, e.g.*, *Delta Air Lines, Inc. v. Export-Import Bank*, 85 F. Supp. 3d 250, 266 (D.D.C. 2015) (no competitor standing where "numerous factual questions remain unresolved and undeveloped, many of which are necessary for determining if and how Plaintiffs might suffer an injury-in-fact from the [agency action]"). As the D.C. Circuit has explained, "the basic requirement common to all [competitor standing] cases" is that the challenged government

[22] *See, e.g.*, STLDI Rule, 83 Fed. Reg. at 38,239 ("[STLDI] is already available and can be purchased as four separate less than 3-month insurance policies"); Karen Pollitz, *et al.*, *Understanding Short-Term Limited Duration Health Insurance*, KFF, April 23, 2018 ("some issuers offer 'four-packs' of short-term policies with sequential effective dates . . . enabling consumers to continue to buy up to a year of short-term coverage at a time."), https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/; KFF, *Enrollment Changes*, *supra* note 17 ("people who have dropped off-exchange coverage . . . may have obtained coverage elsewhere (e.g., through employer plans, or health care sharing ministries, . . . and some may be uninsured"); Goodman, *supra* note 20 (reporting that "[l]arge numbers of Americans are turning to alternatives to Obamacare," including limited benefit indemnity plans and health care sharing ministries).

regulation has caused "an actual or imminent increase in competition, which increase . . . will almost certainly cause an injury in fact." *Sherley*, 610 F.3d at 73.

Such is not the case here. Most importantly, STLDI plans and ACA-compliant plans are in different product markets. The STLDI Rule does not lift regulatory restrictions on CHC's competitors on the Texas Exchange for ACA-compliant plans or open *that* market to new participants. Rather, the STLDI Rule applies to products sold in the market for off-Exchange short-term coverage of limited duration. Moreover, those products cannot be purchased or sold on the ACA-created Exchanges, nor can the millions of Americans who receive subsidies to obtain coverage use those subsidies to purchase STLDI coverage. Not only are STLDI products, by definition, of limited duration, they are not required by federal law to provide protections for pre-existing conditions, coverage of essential health benefits, or guarantees of availability and renewability.[23] Because they are not reasonable substitutes for ACA-complaint plans, as Plaintiffs themselves admit, *see, e.g.*, Compl. ¶ 5 (distinguishing STLDI plans from ACA plans), they do not directly compete with QHPs, thus rendering inapplicable the competitor standing doctrine here. And to the extent enrollees of ACA-compliant plans do consider switching to STLDI plans, the STLDI Rule is "at most, the first step in the direction of future competition." *New World Radio*, 294 F.3d at 172; *see also DEK Energy Co.*, 248 F.3d at 1196 (finding competitive injury unduly speculative where any increase in competition would "depend on . . . market conditions [in the plaintiff's market] and in alternative markets").

B. Plaintiffs Fail to Establish Standing on Behalf of their Provider Members.

Plaintiffs similarly have failed to establish standing for their provider members. In their prior motion for emergency relief, Plaintiffs relied on the declarations of three psychiatrists—Dr.

[23] Accordingly, a KFF poll concluded that 84 percent of consumers do not see STLDI plans as an attractive alternative to ACA-compliant coverage. KFF, *Survey of the Non-Group Market Finds Most Say the Individual Mandate Was Not a Major Reason They Got Coverage in 2018, And Most Plan to Continue Buying Insurance Despite Recent Repeal of the Mandate Penalty*, (Apr. 3, 2018), https://www.kff.org/health-reform/press-release/poll-most-non-group-enrollees-plan-to-buy-insurance-despite-repeal-of-individual-mandate-penalty/ (last visited Feb. 21, 2019).

David Fassler, Dr. Harry Brandt, and Dr. George Kolodner—who expressed concerns that their services may go uncompensated *if* their patients switch to STLDI coverage. PI Mot. at 36-38. And, *if* QHP issuers face a sicker risk pool as a result of the STLDI Rule, plans that do cover their services *may* "institute cost-reduction practices" such as prior authorization requirements, which allegedly will then "increase the amount of uncompensated time the psychiatrist must spend on each patient to ensure their care is covered[.]" *Id.* at 36.

But this is precisely the type of speculative, future harm that cannot satisfy Article III's demanding standards. *See Clapper*, 568 U.S. at 410, 414; *Pub. Citizen*, 489 F.3d at 1295. The "speculative chain of possibilities," *Clapper*, 568 U.S. at 414, depends on: (1) one or more of their patients enrolling in an STLDI plan made possible by the STLDI Rule (which generally will occur only if the patient is not eligible to receive a subsidy sufficient to reduce the cost of ACA-compliant coverage below the cost of STLDI coverage); (2) the plan that the patient chooses not covering the services that the doctors provide[24]; (3) the patient continuing to seek services but being unable to pay for those services; (4) the doctor continuing to provide services; (5) any partial amount the patient is able to pay being less than the contract rate that otherwise would have been paid by an insurance company; and (6) the doctor not passing the cost of that uncompensated care to other patients through higher rates. A similar chain of speculations is further required to support the claim that insurers will react to any loss of enrollees by instituting cost-reduction practices. Plaintiffs have only offered what they believe would be worst case scenarios, which plainly is insufficient to establish Article III standing. *See, e.g.*, *Bloomberg L.P. v. Commodity Futures Trading Comm'n*, 949 F. Supp. 2d 91, 106 (D.D.C. 2013) (dismissing for lack of standing where plaintiff's theory of harm was based on a series of "'worst-case scenario[s]'").

[24] Contrary to Plaintiffs' argument, a number of STLDI policies do cover mental health benefits. *See* KFF, Issue Brief, *Understanding Short-Term, Limited Duration Health Ins.*, at 5-6 (Apr. 2018), http://files.kff.org/attachment/Issue-Brief-Understanding-Short-Term-Limited-Duration-Health-Insurance (last visited Feb. 21, 2019).

In fact, there is no reason to assume that the STLDI Rule will impact these doctors at all. Each of the jurisdictions where they practice, *see* Fassler Decl. ¶ 1, ECF No. 10-3 (Vermont); Brandt Decl. ¶ 1, ECF No. 10-2 (Maryland); Kolodner Decl. ¶ 1, ECF No. 10-8 (Maryland and DC), has enacted laws limiting STLDI policies to three months.[25] The District of Columbia additionally prohibits renewals and imposes additional restrictions on STLDI.[26]

Plaintiffs also previously asserted that provider members of Plaintiff AIDS United will be harmed because the STLDI Rule will cause premium increases and their patients "will be unable to pay" the increased premiums, PI Mot. at 37, requiring the providers to continue treating them for free. But even if the STLDI Rule did cause premium increases for the relevant issuers, there is no basis to assume that Plaintiff AIDS United's patients are among the 13 percent of the Exchange enrollees who do not receive subsidies and are not insulated from the effects of any premium increases, Wu Decl. ¶ 5, or even if they are, that they will be unable to afford to maintain health insurance coverage. These same defects also render Plaintiff Mental Health America's claim of standing highly speculative, and thus legally deficient, as well. *See* Compl. ¶¶ 15, 37-38; PI Mot. at 38 (speculating, without evidence, that "individuals with mental illness are priced out of increasingly expensive ACA-compliant Marketplace plans and their conditions are therefore left untreated").

C. Plaintiffs Fail to Establish Standing on Behalf of their Consumer Members.

Finally, Plaintiffs have failed to establish standing on behalf of consumer members who they claim will encounter higher premiums for ACA-compliant coverage due to the departure of healthier enrollees to STLDI plans. Compl. ¶ 15; PI Mot. at 38-39. As a threshold matter, Plaintiffs fail to identify even a single consumer member who is likely to encounter higher premiums as a result of the STLDI Rule, much less one who is not insulated from premium increases due to

[25] *See* Vt. HB 892 (Act 131); Healthinsurance.org, *Short-Term Health Insurance in Maryland*, https://www.healthinsurance.org/maryland-short-term-health-insurance/.

[26] Healthinsurance.org, *Short-term health insurance in the District of Columbia*, https://www.healthinsurance.org/dc-short-term-health-insurance/#permanent.

subsidies, a failure that is fatal to their claim of standing. *Elec. Privacy Info. Ctr. v. U.S. Dep't of Educ.*, 48 F. Supp. 3d 1, 22 (D.D.C. 2014) (concluding that association plaintiff lacked standing because it failed to identify an individual member that would be injured).

Even assuming Plaintiffs could identify such an unsubsidized member, the 2019 rates have actually stabilized or declined slightly overall, Wu Decl. ¶¶ 18-19, and any rate increases that might occur in 2020 or beyond is inherently speculative. As noted above, whether any particular consumer will in fact encounter higher costs for health insurance—and whether that increase is attributable to the STLDI Rule, the reduction of the tax penalty to $0, or something else—would depend on a slew of state-specific, market-specific, and consumer-specific factors, about which there is no evidence before the Court and which are highly dependent on third parties not before the Court. For this very reason, the D.C. Circuit recently held that consumers of ACA-compliant coverage did not have standing to challenge an HHS policy that was alleged, as here, to increase adverse selection and cause higher premiums. *See generally Am. Freedom Law Ctr.*, 821 F.3d at 49. The D.C. Circuit found that the assumption "that [HHS's] Transitional Policy will cause [plaintiffs] to pay more for their health insurance in the future . . . is speculative" because, among other things, "many factors determine the cost of health care," and changes "in any of these factors could cause costs to increase or decrease[.]" *Id.* at 51. As the Court observed:

> According to Appellants, "basic economic principles" establish a direct link between the supposed decrease in the number of individuals in ACA-compliant risk pools allegedly caused by HHS's [] Policy and the asserted increase in the price of Appellants' health insurance plan. But . . . the effect of various factors, including the size of risk pools, on health insurance pricing is far from "basic," and Appellants have made no concrete allegations, nor provided any specific evidence, establishing that the cost of their health insurance plan is likely to increase in the future, let alone that such an increase will stem from the [] Policy. This is a major missing link in the causal chain Appellants must establish to demonstrate that HHS's [] Policy is a "substantial factor motivating" Appellants' alleged harm.

Id. at 50 (internal citations omitted). Those observations are similarly controlling here.[27]

[27] *See also, e.g.*, *Garelick v. Sullivan*, 987 F.2d 913, 920 (2d Cir. 1993) ("even if some physicians chose to increase their charges . . . in response to the [challenged] scheme," those increases "would

In addition, the D.C. Circuit has held that consumers do not suffer Article III harm simply because a product they desire is more expensive; instead, the consumer must show that as a result of the government policy, the product is "not readily available at a reasonable price." *Coal. for Mercury-Free Drugs v. Sebelius*, 671 F.3d 1275, 1281 (D.C. Cir. 2012). Thus, even if Plaintiffs had met their evidentiary burden to establish that one of their members faces a "certainly impending" increase in insurance costs as a result of the STLDI Rule, they would also need to show that the price increase will be so significant as to render ACA-compliant coverage "not readily available at a reasonable price." Plaintiffs have not done so.

Finally, to the extent Plaintiffs' consumer-members seek to assert standing on the basis that they may buy STLDI without understanding its limitations and subsequently incur medical expenses that are not covered by their plan, that would be a self-inflicted injury, *see Grocery Mfrs. Ass'n*, 693 F.3d at 177, and would again be premised on a chain of speculative contingencies and third-party behaviors, which is insufficient to confer standing. *Williams*, 819 F.3d at 473.

II. Plaintiffs' Claims Fail on their Merits.

A. Standard of Review Under the APA

Plaintiffs' APA challenge is governed by the deferential framework "set out in [*Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 845 (1984), which] applies to judicial review of claims that an agency has acted 'in excess of statutory jurisdiction, authority

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be the product of independent choices by physicians from among a range of economic options" and not fairly traceable to defendants); *Butler v. Obama*, 814 F. Supp. 2d 230, 240 (E.D.N.Y. 2011) (rejecting theory of standing based on increased insurance premiums because "insurance companies have broad discretion in the setting of premiums, and plaintiff has failed to allege any basis for concluding that the elimination of the individual mandate will result in insurance premium decreases for the health coverage that he currently seeks to purchase"); *Peterson v. United States*, 774 F. Supp. 2d 418, 421-26 (D.N.H. 2011) (dismissing for lack of standing because "a judgment in [plaintiff's] favor would not require [the insurer] to rescind or reduce the premium increases" and plaintiff was "merely speculating about how a third party might respond if the Act is struck down"); *Calvey v. Obama*, 792 F. Supp. 2d 1262, 1271 (W.D. Okla. 2011) ("the ACA does not require insurance companies to raise their premiums, and if insurance companies did so, any injury to Plaintiffs would be the result of the insurance companies' independent actions and not the challenged actions of the Defendants." (citation omitted)).

or limitations.'" *Cmty. Health Sys., Inc. v. Burwell*, 113 F. Supp. 3d 197, 211-12 (D.D.C. 2015) (citing *Am. Fed'n of Gov't Emps. AFL-CIO, Local 3669 v. Shinseki*, 709 F.3d 29, 33 (D.C. Cir. 2013)). The *Chevron* framework is based on the presumption "'that Congress, when it left ambiguity in a statute' administered by an agency, 'understood that the ambiguity would be resolved, first and foremost, by the agency, and desired the agency (rather than the courts) to possess whatever degree of discretion the ambiguity allows.'" *City of Arlington v. FCC*, 569 U.S. 290, 296 (2013) (citation omitted). Accordingly, at the first step of the inquiry, the Court must "ask whether Congress has directly addressed the precise question at issue." *Mayo Found. for Med. Educ. & Research v. United States*, 562 U.S. 44 (2011) (internal citations omitted). If the Court concludes that the statute is silent or ambiguous with respect to the specific issue under consideration, the analysis shifts to *Chevron* step two, where "the question for the court is whether the agency's answer is based on a permissible construction of the statute." *City of Arlington*, 569 U.S. at 296 (quoting *Chevron*, 467 U.S. at 842-43). *Chevron* step two is generally coextensive with arbitrary and capricious review. *Judulang v. Holder*, 565 U.S. 42, 52 n.7 (2011).

B. The STLDI Rule Is Comfortably Within the Departments' Authority.

Plaintiffs have contended that the Departments exceeded their authority because the STLDI Rule is a "decision[] of vast 'economic and political significance'" that Congress did not clearly delegate to the Departments and that the Departments have "claim[ed] the power to create a new form of primary health insurance that is exempt from all of the ACA's central requirements[.]" PI Mot. at 13-14 (citing *King v. Burwell*, 135 S. Ct. 2480, 2489 (2015)). They are wrong.

First, it was Congress—not the Departments—that exempted STLDI plans from the individual market insurance reforms. Congress did so in HIPAA, and rather than define STLDI itself, it delegated to the Secretaries of HHS, Labor, and the Treasury the authority under the PHS Act, ERISA, and the Internal Revenue Code to "promulgate such regulations as may be necessary or appropriate to carry out the provisions of this title." HIPAA, Pub. L. No. 104-191 § 2792, 110 Stat 1936, *codified at, e.g.*, 42 U.S.C. § 300gg-92. Congress chose to retain the STLDI exemption when it enacted the ACA without changing the definition of "individual health insurance

coverage." Congress is presumed to have been aware, when it enacted the ACA, that the Departments' long-standing definition of STLDI under the 1997 Rule and the 2004 Rule encompassed plans of less than twelve months and permitted renewal of STLDI with an issuer's consent. *Lorillard v. Pons*, 434 U.S. 575, 581 (1978) ("[W]here, as here, Congress adopts a new law incorporating sections of a prior law, Congress normally can be presumed to have had knowledge of the interpretation given to the incorporated law, at least insofar as it affects the new statute."); *accord Gordon v. U.S. Capitol Police*, 778 F.3d 158, 165 (D.C. Cir. 2015). The Court must therefore presume that Congress approved that definition. *Cf. Merrill Lynch, Pierce, Fenner & Smith, Inc. v. Curran*, 456 U.S. 353, 381–82 & n.66 (1982) (holding that Congress's "re-enact[ing] a statute without change" or "incorporating sections of a prior law" demonstrates an intent to "le[ave] intact" an agency's interpretation); *see also Orton Motor, Inc. v. HHS*, 884 F.3d 1205, 1213 (D.C. Cir. 2018) (court may rely on regulations to interpret authorizing statute where Congress legislated with the restrictions in those regulations in mind). That presumption should control this case.

Second, even if Plaintiffs could overcome this clear indication of congressional intent, they have overstated the economic significance of the STLDI Rule. While the STLDI Rule is expected to provide important relief for *individual consumers* seeking temporary coverage, as discussed above, its overall market effects are expected to be relatively modest. *See* 83 Fed. Reg. at 38,236 (projecting premium increases of approximately 1 percent in 2019 and 5 percent by 2028). That is because, among other things, approximately 87 percent of Exchange enrollees receive subsidies that insulate them from the effect of rate increases for ACA-compliant coverage. Wu Decl. ¶ 5. Those subsidies cannot be used to purchase an STLDI plan, and the enrollees who receive them are generally unlikely to switch to STLDI plans. For the remaining approximately 13 percent of the Exchange market enrollees who do not receive subsidies, at least some will remain in the Exchange market due to the more comprehensive coverage provided by ACA-compliant plans, particularly if they have pre-existing conditions that are not covered by the available STLDI plans in their geographic areas. 83 Fed. Reg. at 38,235-36. Some others may choose to go uninsured

rather than purchase ACA-compliant coverage because the individual mandate tax penalty has been reduced to $0. *Id.* at 38,316-17. Moreover, the rates for 2019 remain stable (1.5 percent lower) overall, Wu Decl. ¶ 18, demonstrating that early projections of immediate market-wide premium increases due to the STLDI Rule have not occurred.[28] Even among insurers that did increase their rates in 2019, the increase is more modest than some projected, and is almost certainly attributable to other changes, including but not limited to the tax reform, increases in the cost of medical services and prescription drugs, regulatory uncertainty, and changing demographics. *See Am. Freedom Law Center*, 821 F.3d at 51 ("[M]any factors determine the cost of health care, including administrative costs, drug costs, and the health and age of the national populace.").[29]

Third, contrary to Plaintiffs' assertion, the Departments have not claimed the unilateral authority to create a new form of primary insurance by restoring a definition that has existed since 1997. The 1997 definition not only permitted STLDI plans to last for up to twelve months but also allowed such plans to be renewed indefinitely with the consent of the issuer. *See* 1997 Rule, 62 Fed. Reg. at 16,928 (defining STLDI as a plan expiring within twelve months of its effective date after accounting for "any extensions that may be elected by the policyholder *without* the issuer's consent" (emphasis added)); 2004 Rule, 69 Fed. Reg. at 78,748 (same). If the Departments possessed authority in 2016 to *shorten* the definition from a maximum of 364 days to less than three months and limit renewals—as Plaintiffs clearly believe—the decision to restore the Departments' 1997 definition insofar as it permitted STLDI plans with a contract term of less than

[28] *See, e.g.*, 83 Fed. Reg. at 38,238 (the Urban Institute estimated 18 percent attributed to effect of the STLDI Rule and the tax reform); *id.* at 38,237 (CBO estimated 2 to 3 percent attributed to the STLDI Rule and another recent rule); *id.* at 38,238 (the Commonwealth Fund estimated 2.7 percent attributed to the STLDI Rule and the lifting of certain behavioral barriers); *see also* Wakely Report at 1 (0.7 percent to 1.7 percent attributed to the STLDI Rule).

[29] As to the 36-month renewal provision, the Departments projected that this provision would have only a negligible economic impact on the markets, 83 Fed. Reg. at 38,236, particularly given that states may determine that such renewal is inappropriate for their consumers, and indeed, some have already so determined.

twelve months and further allowed renewals with the issuer's consent must fall within the Departments' authority as well. Moreover, as discussed further below, *see infra* Part II.C.1, the Departments plainly had the authority to interpret the phrase "limited duration" to mean something different than "short-term" given the established interpretive cannon that statutory language "should be construed so that effect is given to all its provisions, so that no part will be inoperative or superfluous, void or insignificant[.]" *Corley v. United States*, 556 U.S. 303, 314 (2009) (citations and quotation marks omitted). That is especially true given the Departments' statutory authority to "promulgate such regulations as may be necessary or appropriate to carry out the provisions of" HIPAA and the ACA. *See* 42 U.S.C. § 300gg-92; HIPAA, Pub. L. No. 104-191 § 104.

C. The STLDI Rule Is Not Contrary to Law.

Plaintiffs have also contended that the STLDI Rule is contrary to law because the text and structure of the ACA "unambiguously preclude[]" the STLDI Rule. PI Mot. at 16. This theory is similarly defective.

1. The STLDI Rule Is Consistent with the Statutory Text.

A contract term of less than one year is consistent with the statutory phrase "short-term." Congress did not define this ambiguous phrase. As Plaintiffs have acknowledged, "short-term" is a *relative* phrase, meaning "occurring over or involving a relatively short period of time." PI Mot. at 22 (citing Merriam-Webster Dictionary, "short-term"); *see also Am. Safety Ins. Co. v. Page's Thieves Mkt., Inc.*, No. 2:15-CV-3266-PMD, 2016 WL 4430839, at *4 (D.S.C. Aug. 22, 2016) ("the 'term' in 'short-term' means 'a fixed or limited period for which something . . . lasts or is intended to last.'" (citation omitted)). Relative to the lifetime over which a person may require health insurance, a period of less than one year is obviously short. Moreover, even if "the relevant benchmark is the length of a standard health insurance plan: one year," as Plaintiffs have asserted, PI Mot. at 22, a term of less than one year is "a fixed or limited period" of coverage that is shorter than the length of that standard plan. It is, therefore, "relatively short."

Plaintiffs nevertheless have claimed that, even though a term of less than one year is shorter than a standard plan, it is not short in a "meaningful sense." *Id*. at 22. But definitions of contractual

instruments necessarily entail dividing lines, and an ambiguous phrase like "short term" presumes substantial discretion to draw those lines. Plaintiffs fail to provide any non-arbitrary framework—much less one rooted in statutory text—for assessing whether a contract period is short in a "meaningful sense." *Id*. Indeed, the phrase "short term" is frequently used to describe periods of one year or less. For example, a "short-term investment" is one that must be liquidated within one year.[30] "Short-term gain" is profit from an asset that has been held for one year or less.[31] And a "short-term loan" is "[a] loan with a due date of less than one year[.]" Loan, Black's Law Dictionary (10th ed. 2014). There is no merit to Plaintiffs' contention that the phrase "short-term" must be read to refer to some unspecified contract term of less than 364 days. Rather, Plaintiffs simply ask the Court to supplant the judgment of the Departments—and of Congress, which did not disturb the Departments' longstanding definition when it enacted the ACA—with their own.

Plaintiffs' arguments on this point also are implausible in light of the fact that numerous states have chosen to define "short-term" in the same way as the Departments. *See, e.g.*, S.D. Admin. R. 20:06:40:02 (defining "short-term, limited duration insurance" to mean "health insurance coverage provided under a contract . . . that has an expiration date specified in the contract that is within 12 months of the date the contract becomes effective[.]"); 28 Tex. Admin. Code § 3.3002(18) (same); *see also* NAIC 2016 Comment, at 1 (noting that "[s]hort term, limited duration insurance has long been defined as a policy of less than 12 months both by the states and the federal government"). The fact that many states—who have long been the primary regulators of insurance—agree with the Departments that "short-term" insurance can last for up to 364 days amply demonstrates that the Departments' interpretation is reasonable and consistent with how that term is understood in the industry. *See, e.g.*, *Drummond Coal Co. v. Hodel*, 796 F.2d 503, 505 (D.C. Cir. 1986) (rejecting "'plain meaning' argument" where agency's interpretation of phrase left undefined by Congress was supported by "industry practice").

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[30] *See* https://www.investopedia.com/terms/s/shorterminvestments.asp (last visited Feb. 21, 2019).

[31] *See* https://www.investopedia.com/terms/s/short-term-gain.asp (last visited Feb. 21, 2019).

The STLDI Rule's construction of the phrase "limited duration" to encompass renewals or extensions of up to 36 months is similarly consistent with the statutory text. Plaintiffs have acknowledged that the word "[l]imited" means "[r]estricted in size, amount, or extent." PI Mot. at 26 (citation omitted). The word "duration" means "the time during which something exists or lasts."[32] A 36-month cap on coverage under an STLDI plan "[r]estrict[s]" the "time during which [an STLDI contract] exists or last" and therefore gives reasonable meaning to the phrase "limited duration." To the extent Plaintiffs have focused on the fact that some states have capped the permissible period of renewability to a shorter duration or prohibited renewability altogether, *see* PI Mot. at 26 n.33, that fact by no means demonstrates that a maximum duration of 36 months is not also "limited" in the plain sense meaning of the phrase. Indeed, the NAIC definition of "Short-Term Medical" expressly notes that such "policies may be renewable for multiple periods."[33]

2. Congress Did Not Clearly Preclude the STLDI Rule.

Nor is it improper for the Departments to use STLDI to "expand[] more affordable coverage options to consumers" and "reduc[e] the number of uninsured individuals," as Plaintiffs have asserted. PI Mot. at 16 (citing 83 Fed. Reg. at 38,218). According to Plaintiffs, "Congress determined that the [only] way to" expand affordable coverage options and reduce the number of uninsured individuals is through the guaranteed issue and community rating reforms, which in turn would ensure that all health insurance consumers would be "members of a single risk pool," PI Mot. at 16 (citing 42 U.S.C. § 18032(c)), whereby the higher costs of the less healthy are offset by the relatively lower costs of the healthy. But Congress cannot have been so single-minded. As demonstrated above, by choosing to exempt STLDI coverage from the ACA's individual market regulations, Congress clearly intended that such coverage not be subject to the federal "single risk pool" requirements. Indeed, as discussed above, Congress made the same judgment as to numerous other alternative health coverage options that it excluded from the single risk pool

[32] *See* https://www.merriam-webster.com/dictionary/duration (last visited Feb. 21, 2019).

[33] *See* https://www.naic.org/consumer_glossary.htm#S. (last visited Feb. 21, 2019).

requirement. It is illogical to argue that Congress incorporated HIPAA's exemption of STLDI from the ACA's individual market reforms while also intending STLDI enrollees to be part of the single risk pool. In any event, to prevail on this point, Plaintiffs must show that Congress "directly addressed the precise question" of the maximum term and duration of STLDI coverage. *Mayo Found. for Med. Educ. & Research v. United States*, 562 U.S. 44 (2011). They cannot do so.

The Senate and House Committee reports discussing HIPAA's objective are not to the contrary. *See* PI Mot. at 23. The reports discussed the overarching purpose of "increas[ing] access to and portability of health insurance coverage for individuals and their families so that they could retain their health insurance when they changed or lost their jobs." *See* PI Mot. at 22-23 (citing S. Rep. No. 104-156; H.R. Rep. No. 104-496). But HIPAA, by its terms, did not limit STLDI to circumstances involving a change in employment status. Nor did HIPAA purport to regulate the entirety of insurance markets. Indeed, the lion's share of its provisions extend primarily to *group* plans, with limited impact on the individual market. *See* HIPAA, Pub. L. No. 104-191 §§ 701-707, 2701-2713. Nothing in those reforms suggests that Congress would have been troubled by a 364-day STLDI policy for individuals seeking gap coverage outside that market.

HIPAA's reforms to the individual insurance market likewise do not show that Congress "directly addressed" the permissible term and duration of STLDI coverage. HIPAA imposed only two market reform requirements on issuers of individual market plans: (1) guaranteed availability of coverage for individuals with at least 18 months of prior "creditable coverage," without a significant break in coverage of 63 days or more; and (2) guaranteed renewability of coverage at the option of the individual. 42 U.S.C. §§ 300gg-41(a), 300gg-42(a). There is no indication that the presence of STLDI coverage of up to 364 days or the allowance of limited renewal of those plans for up to 36 months creates any regulatory incongruity with these two protections. Indeed, beyond these two constraints, individual health plans remained free under HIPAA to deny coverage, impose pre-existing condition exclusions, and discriminate based on health status, just as STLDI plans could. Similarly, while HIPPA required individual health insurance coverage to be guaranteed renewable and elected to exempt STLDI from that requirement, it did not prohibit

STLDI issuers from allowing their plans to be renewed should they choose to do so. Thus, Plaintiffs' contention that Congress clearly intended "that STLDI coverage be non-renewable," Compl. ¶ 91, is incorrect.

In fact, HIPAA clearly indicates that Congress did not want to unduly restrict the availability of STLDI coverage. Congress provided that HIPAA's individual market guaranteed availability of coverage protections and group health plan coverage protections for coverage without a preexisting condition exclusion were contingent upon an individual having had twelve or eighteen months of prior "creditable coverage" 42 U.S.C. § 300gg-41(b)(1)(A). Moreover, a break in such "creditable coverage" of sixty-three or more days at any time during that period rendered a person ineligible for these protections. *Id*. § 300gg-3(c)(2)(A). Congress recognized STLDI coverage as a type of "creditable coverage" because it falls within the broader definition of "health insurance coverage" even though it is not "individual health insurance coverage." *See* 42 U.S.C. §300gg-3(c)(1)(B); H.R. Rep. No. 104-736, at 180 (1996) ("The conferees intend that creditable coverage includes short-term, limited coverage."); *see also* 45 C.F.R. § 146.113(a)(1)(ii) (STLDI is a type of "health insurance coverage"). That decision to permit an individual to use STLDI coverage to satisfy the creditable coverage requirement (and avoid forfeiture of any prior creditable coverage) suggests that Congress understood that STLDI plans serve an important purpose and wanted to encourage such coverage as an alternative to having no insurance at all. Restricting STLDI plans to periods of less than three months—as Plaintiffs advocate—would have made it more difficult for an individual to maintain the unbroken period of creditable coverage necessary to invoke HIPAA's protections because of possible breaks in his or her coverage during the underwriting period or even a loss of coverage altogether if he or she developed a pre-existing condition during that time. Congress clearly did not intend to create such obstacles to the protections it created under HIPAA.

Nor is there anything in the ACA suggesting that Congress intended to restrict consumers' access to STLDI coverage; on the contrary, as discussed above, the ACA retained the existing exemption for STLDI plans from the ACA's individual market reforms. Congress also chose to

not provide a statutory definition for STLDI in the ACA and was presumed to be aware and approve of the Departments' long-standing definition of STLDI that permitted plans of less than twelve months in duration when it enacted the ACA. The fact that Congress, through the "interdependent" provisions on guaranteed issue, community rating, essential health benefits, and a "single risk pool," intended to foster a robust market for ACA-compliant coverage does not mean that Congress intended to pursue that market at all costs. *See Kucana v. Holder*, 558 U.S. 233, 252 (2010) ("[N]o law pursues its purpose at all costs, and . . . the textual limitations upon a law's scope are no less a part of its 'purpose' than its substantive authorizations."). This observation is confirmed by Congress's exclusion, in varying degrees, of several health coverage options from the ACA's market reforms, all of which might draw some younger, healthier people out of the single risk pool. They include "grandfathered plans," which are plans that existed prior to the ACA and therefore are more likely to have been sold to individuals without serious health conditions, 42 U.S.C. § 18011, and student health insurance plans, which are more likely to be issued to younger—and again healthier—enrollees, *id*. § 18118. Congress also substantially expanded Medicaid eligibility notwithstanding the fact that such an expansion could draw a substantial number of people out of the market for ACA-compliant insurance.[34] These exemptions and other policy choices refute any notion that Congress's concerns about adverse selection and market segmentation were so strong as to wholly foreclose alternatives to ACA-compliant insurance in all circumstances. *Cf. Rodriguez v. United States*, 480 U.S. 522, 525-26 (1987) ("Deciding what competing values will or will not be sacrificed to the achievement of a particular objective is the very essence of legislative choice—and it frustrates rather than effectuates legislative intent simplistically to assume that whatever furthers the statute's primary objective must be the law.").

Plaintiffs have argued that the Court must interpret "short-term, limited duration insurance" to align with the phrase "short coverage gap" under section 5000A(c)(4) of the Internal Revenue Code, PI Mot. at 25. The latter is precisely defined in the Code as a period of "less than 3 months"

[34] *See* CMS Trends, *supra* note 21, at 2 (noting that Exchange "enrollment can be strongly impacted by changes in state Medicaid").

during which, under the ACA, a failure to have "minimum essential coverage" would not subject an individual to a tax penalty. 26 U.S.C. § 5000A(e)(4). Section 5000A confirms that Congress knows how to precisely define a "short" period when it wishes to do so, yet it did not do so in providing for STLDI. Nor does the statutory structure require the coverage gap referred to in section 5000A to be the same length of time as STLDI plans exempted under HIPAA. The two terms arise in different contexts serving different purposes. Congress's judgment as to when a tax penalty is appropriate under section 5000A says nothing about Congress's judgment about whether, in the event of a lapse in coverage, it would be preferable to afford people the opportunity to obtain STLDI rather than no insurance at all. If anything, Congress's decision to retain HIPAA's exemption for STLDI plans from the definition of "individual health insurance coverage" suggests that Congress thought it would be preferable. 42 U.S.C. § 300gg-91(b)(5). In addition, Congress has since reduced the tax penalty to $0 starting in 2019, suggesting that it no longer believes it appropriate to penalize individuals for a coverage gap of any length. *See Maryland v. United States*, No. ELH-18-2849, 2019 WL 410424, at *8 (D. Md. Feb. 1, 2019) (quoting floor debate statements that under the TCJA that "you will no longer be punished" if "you decide [an ACA] plan doesn't fit your family" (citing 163 Cong. Rec. S7672 (daily ed. Dec. 1, 2017)).

Moreover, a "short coverage gap" is not the only scenario in which Congress originally exempted individuals from the tax penalty. Congress also exempted individuals who, due to hardship or financial constraints, are unable to obtain minimum essential coverage, and it imposed no time limit on these waivers. 26 U.S.C. § 5000A(e). Congress thus acknowledged that the circumstances in which a person might require short-term coverage are not necessarily limited to three-month increments. Under Plaintiffs' construction, however, individuals exempted from the individual mandate due to hardships nevertheless should not be able to obtain STLDI coverage for the full duration of their hardship, but should be uninsured, simply because, according to Plaintiffs, Congress "judg[ed] that individuals should not have coverage that falls outside the minimum essential coverage requirements[.]" PI Mot. at 25. Such a construction would make the perfect the enemy of the good. Plaintiffs cite nothing to suggest that Congress intended such an absurd

outcome. *Cf. Griffin v. Oceanic Contractors, Inc.*, 458 U.S. 564, 575 (1982) ("[I]nterpretations of a statute which would produce absurd results are to be avoided if alternative interpretations consistent with the legislative purpose are available.").

The ACA's limitation of the waiting period for group health insurance coverage to ninety days does not bolster Plaintiffs' argument regarding the three-month rule. *See* PI Mot. at 25. If STLDI plans must be limited to *less* than three months, individuals who switch to group coverage with a ninety-day waiting period may not be able to avoid a one-day loss of coverage, even if they acquire an STLDI plan in the interim. Moreover, a less than three month STLDI policy to cover some of an initial waiting period would be of little help to an individual who faces a period of unemployment *before* obtaining a new job. Nor would it help those whose employer-sponsored coverage is contingent upon conditions of eligibility, which may result in coverage gaps that extend far longer than 90 days. *See* 79 Fed. Reg. 10,296, 10,297 (Feb. 24, 2014) (providing for a combined "measurement period," in which eligibility for coverage is confirmed, and "waiting period" of up to thirteen months before employer-sponsored coverage might commence). Plaintiffs' construction would thus construe a "waiting period" provision intended to *facilitate* prompt coverage for individuals enrolling in group plans in a way that severely *restricts* an individual's coverage options during the period that precedes the commencement of group coverage. There is no indication Congress intended such a harsh result.

D. The STLDI Rule Is Not Arbitrary and Capricious.

The STLDI Rule is not arbitrary or capricious. As noted, arbitrary and capricious review is generally coextensive with the deferential review under *Chevron* step two. *Judulang*, 565 U.S. at 52 n.7. Under this standard, agency action is not arbitrary and capricious unless "the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Adirondack Med. Ctr. v. Sebelius*, 891 F. Supp. 2d 36, 44 (D.D.C. 2012) (citation omitted), *aff'd*, 740 F.3d 692 (D.C. Cir. 2014). An agency's decision must

be upheld if the agency examined the relevant data and established a "rational connection between the facts found and the choice made." *Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 168 (1962). A decision that is not fully explained may nevertheless be upheld "if the agency's path may reasonably be discerned." *Bowman Transp., Inc. v. Arkansas–Best Freight Sys., Inc.*, 419 U.S. 281, 286 (1974). And, judicial deference is at its apex where, as here, the regulation at issue "'concerns a complex and highly technical regulatory program[.]'" *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994) (citation omitted).

1. The Departments Considered Relevant and Appropriate Factors.

Plaintiffs take issue with the factors the Departments allegedly did and did not consider when adopting the STLDI Rule. *See* Compl. ¶¶ 119-21. Plaintiffs fault the Departments for supposedly considering the fact that STLDI "policies are priced so that the premium paid by an individual reflects the risks associated with insuring th[at] particular individual." *Id.* ¶ 119. According to Plaintiffs, that consideration is "flatly contrary to the community rating reforms of the ACA." *Id*. However, the quoted statement appears in the Rule's Regulatory Impact Analysis, which simply described as a factual matter why STLDI issuers were likely to experience an increase in premium revenues and profits as a result of the Rule. *See* 83 Fed. Reg. at 38,229. There is no indication the Departments specifically relied on that aspect of STLDI pricing—as opposed the general affordability and flexibility that such pricing permits—as a basis for their decision. Indeed, in a later portion of the Rule, the Departments acknowledged that this facet of STLDI pricing was one of the potential costs—not benefits—of the rule, noting that it could "weaken states' individual market single risk pools" and lead "individual market issuers [to] . . . suffer financial losses[.]" *Id.* at 38,234. Plaintiffs are equally misguided in suggesting that the Departments' observation that STLDI policies are "unlikely to include all the requirements applicable to individual market plans," was viewed as a "key purported benefit" of the Rule. Compl. ¶ 119. Again, the quoted statement appears in a section of the STLDI Rule discussing how STLDI plans function in order to assess the Rule's potential *costs*, not its benefits. 83 Fed. Reg. at 38,213. Merely describing STLDI products in weighing the Rule's potential costs and benefits

for insurance market participants is not the same as a reliance on impermissible factors. To the extent Plaintiffs mean that the Departments were not permitted to weigh considerations of affordability and availability of coverage in expanding access to STLDI, they are wrong. The ACA was intended to "increase the number of Americans covered by health insurance and decrease the cost of health care." *NFIB*, 567 U.S. at 538. To the extent Plaintiffs believe that affordability and choice can only be pursued through initiatives that facilitate *ACA-compliant* coverage, PI Mot. at 19-21, there is no support in the ACA for that belief. Indeed, the D.C. Circuit recently held that HHS overstepped its authority by restricting non-ACA compliant coverage in favor of ACA-compliant coverage where Congress intended that non-compliant coverage continue to exist. *See Cent. United Life Ins. Co. v. Burwell*, 827 F.3d 70, 72-75 (D.C. Cir. 2016).

Nor did the Departments fail "to adequately consider alternatives to their regulatory action," such as adoption of a 6-month or 9-month initial term for STLDI. Compl. ¶¶ 120-21. The Departments did consider adopting an "initial contract term [that] was somewhat longer than less than 3 months," such as, "for example, less than 9 months," but concluded that such an approach would be less effective in ensuring that individuals can maintain continuous coverage, 83 Fed. Reg. at 38,218, because upon expiration of a shorter STLDI plan,

> an individual . . . would be subject to re-underwriting if they did not have a renewal guarantee, and would possibly have his or her premium greatly increased as a result. The issuer could also decline to issue a new policy to the consumer based on preexisting medical conditions. Also, . . . the individual would not get credit for money spent toward [any] deductible during the previous [term] . . . [and any] waiting period on preexisting conditions or on specific benefits would start over, leaving the consumer without coverage for the condition(s) or benefit(s) until the new waiting period expires.

Id. The Departments thus reasonably concluded that a term of less than 12 months was preferable because it would "mitigate[e] these circumstances" more than a term of 6 or 9 months. *Id.*

Plaintiffs' contention that the Departments failed to consider the market effects of "permitting the sale of consecutive STLDI plans at a single time . . . in light of" the 36-month renewability provision, Compl. ¶ 121, is similarly misplaced. First, the Rule does not itself permit "the sale of consecutive STLDI plans at a single time"; it simply acknowledges that such

transactions were allowed by the prior rule and are not precluded by the Rule either. *See* 83 Fed. Reg. at 38,220 ("Nothing in this final rule precludes the purchase of separate insurance contracts that run consecutively[.]"). Moreover, the Departments' economic analysis of the impacts of the Rule *did* consider both the 36-month renewability provision, which "was estimated to have a negligible impact," *id.* at 38,226, and the fact that STLDI plans can issue consecutive policies. *See* OACT Estimate at 1 (noting as a background fact to its analysis that the Rule did not "prevent companies from . . . issuing new policies to individuals at the end of the 1-year . . . term").

2. The Departments Provided a Well-Reasoned Explanation for Their Modification of the 2016 STLDI Rule.

Plaintiffs additionally assert that the Departments changed their prior, 2016 definition of STLDI without providing the required reasoned explanation. Compl. ¶¶ 115-16; PI Mot. at 28. On the contrary, the Departments fully explained their decision. They first explained that although the October 2016 final rule "was intended to boost enrollment in individual health insurance coverage by reducing the maximum duration of coverage in short-term, limited-duration plans, it did not succeed in that regard." 83 Fed. Reg. at 38,214. Instead, "average monthly enrollment in individual market plans decreased by 10 percent between 2016 and 2017, while premiums increased by 21 percent." *Id.* Therefore, the Departments determined, "the expansion of additional coverage options such as short-term, limited-duration insurance is necessary, as premiums have escalated and affordable choices in the individual market have dwindled." *Id.*

The Departments also addressed the contention, reiterated in this case, that the 36-month renewability provision amounted to a change in policy. The Departments noted that the 2016 rule "also allows renewals" and that "[t]he only difference between the two rules [in that respect] is that the [2016] rule allows renewals to the extent the total duration of coverage . . . is less than 3 months, whereas this final rule allows renewals to the extent the maximum duration of a policy . . . is up to 36 months." *Id.* at 38,220; *see also id.* at 38,220 n.34 (noting that the 1997 Rule similarly permitted extensions). As the Departments explained, the STLDI Rule, however, better gives meaning to both "limited duration" and "short-term"; specifically, "the term 'limited-

duration' refers to a longer time period than 'short-term,' because, while an insurance policy's duration is (absent cancellation) never shorter than its term, a policy's term can be shorter than its duration (if the policy is renewed or extended)." *Id.* at 38,220. This interpretation, the Departments found, is consistent with "the canon of statutory construction," which "disfavors rendering one or more statutory words or phrases redundant." *Id.*

Finally, the Departments reasoned that, in contrast to individual and group insurance policies, which, since the enactment of HIPAA, generally "must be guaranteed renewable indefinitely," *id*. at 38,221, STLDI coverage typically serves a transitory function, *id*. To determine the appropriate limits on the duration of such coverage, the Departments looked to the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), which establishes an analogous form of transitory coverage by "requir[ing] certain group health plans to extend group health coverage to certain individuals otherwise losing that coverage . . . for a minimum of 18, 29, or 36 months, depending on the nature of the qualifying event that triggers the temporary coverage period." *Id*. The Departments explained that "[s]imilar to COBRA, short-term, limited-duration insurance also serves as temporary coverage for individuals transitioning between other types of coverage" and "[b]y allowing COBRA coverage to last up to 36 months in some circumstances, Congress recognized that 36 months qualifies as a temporary period of transition, during which coverage of limited duration may be useful[.]" *Id.* The Departments noted that the Federal Employees Health Benefits Program has similar provisions for temporary coverage of up to 36 months. 83 Fed. Reg. at 38,221 & n.36. The Departments then reasonably concluded that there were "strong policy considerations" for adopting a similar term as COBRA. *Id.*

In sum, the Departments (1) acknowledged that they were deviating from their 2016 Rule, (2) explained that such deviation was warranted because the 2016 Rule had not succeeded in serving its intended purpose, (3) explained that their interpretation of the phrase "short-term, limited duration" was consistent with both the 1997 Rule and the statutory text, and (4) explained that they were extending the allowable duration beyond the initial contract term in a manner that

aligned with COBRA's protections for those transitioning out of group coverage. The Departments have provided a reasoned explanation for the STLDI Rule.

3. The Purported Harms that Plaintiffs Claim Will Result from the STLDI Rule Do Not Render It Unlawful.

Plaintiffs also claim that the STLDI Rule is arbitrary and capricious "in light of the significant adverse effects it will have on the health insurance market" and "individuals in need of health insurance." Compl. ¶ 117. Plaintiffs have noted that "an individual who enrolls in an STLDI plan will . . . run[] the risk of losing his or her eligibility to enroll in full coverage even if he or she later develops an illness or condition that requires costly treatment." PI Mot. at 30. But that is precisely why STLDI coverage should *not* be artificially constrained to three months. Since the expiration of an STLDI policy does not trigger a special enrollment period ("SEP") in the individual market, a person needing additional short-term coverage after the expiration of a less than three month STLDI plan could be left without any coverage options, particularly given that open enrollment for ACA compliant plans is on an annual basis. In contrast, an STLDI plan of 364 days will cover the consumer through the next open enrollment period where she will have the option of obtaining ACA-compliant coverage, if she has not yet obtained other primary coverage. That flexibility thus ensures that individuals can have seamless coverage during transitory periods. There is every indication that Congress intended such an outcome.

Plaintiffs also have suggested that the SEP provisions of the ACA support their claims because "[u]nder HHS's regulations, the special enrollment period . . . lasts for 60 days, and new coverage will begin the month after enrollment." PI Mot. at 30. Thus, according to Plaintiffs, an individual who loses coverage due to an event that qualifies for an SEP might obtain seamless coverage if she purchases an STLDI policy to cover the period of the SEP and any waiting period before that. *Id.* at 29-30. This hypothetical set of circumstances, however, does not remotely cover the universe of circumstances in which persons might need short-term coverage. The SEP framework provides little comfort to individuals who do not qualify for an SEP because (for example) they miss an open enrollment period or lose coverage for nonpayment, nor does it help

those who do not know when they will be able to afford new ACA-compliant coverage or who cannot commit to a year of coverage. Those are the very people the STLDI Rule seeks to help.

Finally, Plaintiffs take issue with the STLDI Rule's effective date, claiming both that insurers "could not fully anticipate" the timing and that the Departments failed to respond to comments from states requesting a delayed effective date. Compl. ¶ 118. The first assertion is belied by CHC's own rate filings referencing the anticipated STLDI Rule as justification for new rates in 2019, Wu Decl. ¶ 16, and the fact that the Proposed STLDI Rule specifically stated the Departments' intent to make the proposed changes "effective 60 days after publication of the final Rule." 83 Fed. Reg. at 7440. The second assertion is mistaken. The Departments expressly acknowledged that some states had "concerns about the timing of this rule, noting that [they] may want to modify existing laws and regulations," and also recognized that a 60-day effective date "might cause challenges for some states and issuers as they move to adopt, enforce, and comply with the final rule." 83 Fed. Reg. at 38,226. The Departments explained, "[h]owever, [that] as stated elsewhere in this final rule, [we] believe there is a critical need to expand access to health coverage choices" and therefore the proposed changes "must be applicable as soon as possible." *Id.* Thus, the Departments responded to states' concerns about the effective date.

In sum, the STLDI Rule conforms to the statutory text and reasonably accounts for the needs of consumers seeking short-term coverage options. The Rule is not arbitrary and capricious.

E. The Departments Satisfied the APA's Notice and Comment Requirements.

Finally, Plaintiffs' procedural claim that the Departments violated the notice requirements of the APA, Compl. at 49 ¶ 87, is meritless as well. Under the APA, an agency must provide notice of "either the terms or substance of the proposed rule or a description of the subjects and issues involved." 5 U.S.C. § 553(b)(3). This requirement is "designed (1) to ensure that agency regulations are tested via exposure to diverse public comment, (2) to ensure fairness to affected parties, and (3) to give affected parties an opportunity to develop evidence in the record to support their objections to the rule and thereby enhance the quality of judicial review." *Int'l Union, United Mine Workers of Am. v. Mine Safety & Health Admin.*, 407 F.3d 1250, 1259 (D.C. Cir. 2005)

(citation omitted). An agency's notice must therefore "be sufficient to fairly apprise interested parties of the issues involved, but it need not specify every precise proposal which [the agency] may ultimately adopt as a rule." *Nuvio Corp. v. FCC*, 473 F.3d 302, 310 (D.C. Cir. 2007) (citation and quotation marks omitted). The notice requirement is met as long as the final rule is a "logical outgrowth" of the rule originally proposed. *Ne. Md. Waste Disposal Auth. v. EPA*, 358 F.3d 936, 951-52 (D.C. Cir. 2004).

Plaintiffs contend that the Departments violated these requirements because they "failed to disclose that they intended to permit STLDI plans to be renewable at all, let alone for a period of up to 36 months." Compl. at 49 ¶ 87. That is incorrect. In proposing to allow STLDI with "a maximum coverage period of less than 12 months after the original effective date of the contract," the Departments specifically requested comment on "*whether the length of [STLDI] should be some other duration*" and the "*conditions [in which] issuers should be able to allow [STLDI] to continue for 12 months or longer with the issuer's consent*[.]" STLDI Proposed Rule, 83 Fed. Reg. at 7439, 7440, 7441 (emphasis added). The Departments also solicited input on processes that could help "expedite[] or streamline[]" a consumer's reapplication for STLDI. *Id.* at 7440. And the Departments expressly referenced President Trump's October 12, 2017 Executive Order, directing the Secretaries to "consider allowing [STLDI] to cover longer periods *and be renewed by the consumer*." *Id.* at 7438 (emphasis added) (citing Executive Order 13813). The Departments thus unambiguously alerted interested parties of the "issues involved," *Nuvio Corp.*, 473 F.3d at 310—namely the consideration of whether, when, and how consumers should be permitted to retain STLDI policies beyond a period of twelve months. *See, e.g.*, *Connecticut Light & Power Co. v. Nuclear Regulatory Commission*, 673 F.2d 525, 533 (D.C. Cir. 1982) (agency complied with APA where "notice of proposed rule-making clearly revealed both the precise 'subject matter' and the 'issues' involved" and the "final rules were simply more stringent versions of the proposed rules") (quoting 5 U.S.C. § 553(b)).

Moreover, Plaintiffs cannot seriously contend that the Departments "failed to disclose that they intended to permit STLDI plans to be renewable" when *Plaintiffs themselves* addressed the

issue of renewability in their comments. *See* A.R.193912 ("ACAP objects to any *renewals* of STLDI coverage"); A.R.195552 (NAMI) ("Extending the period and *renewability* of short-term plans would . . . negatively impact the families and individuals we represent."); A.R.195364 (AIDS United) ("Issuers Should Not Be Allowed to *Renew* Short-Term Plans"). Countless other commenters also addressed renewal. *See, e.g.*, A.R.181564 ("I . . . hope that *renewable* short-term coverage becomes available"); A.R.181587 ("I am against short-term health insurance plans that last more than a few months or *are renewable*"); A.R.181602 (STLDI "should not be allowed to be extended or *renewed*"); A.R.181614 ("a 12 month *renewable* term[] . . . is a very good fit for many people") (all emphases added) [35] These comments themselves establish that the renewability provision is a logical outgrowth of the Proposed STLDI Rule. *See, e.g.*, *Ne. Md. Waste Disposal Auth.*, 358 F.3d at 952 (finding agency's notice adequate where "[n]umerous commenters . . . filed comments" on the pros and cons of the agency action); *Appalachian Power Co. v. EPA*, 135 F.3d 791, 816 (D.C. Cir. 1998) (notice requirement satisfied where commenters "clearly understood" that a matter was under consideration). Plaintiffs' notice and comment claim should be rejected.

CONCLUSION

For the foregoing reasons, Defendants respectfully request that summary judgment be entered in favor of the Departments.

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Respectfully Submitted,

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[35] *See also, e.g.*, A.R.181654 (STLDI "should be extended to 12 month period with the option to renew"); A.R.181693 ("make it renewable year to year so I don't have to start with a new policy every year"); A.R.181699 ("They cannot be renewable."); A.R.181790 ("Please . . . make [STLDI] eligible for renewal"); A.R.182216 ("I am in favor of the 364+ day policies that are renewable.").

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